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ABSTRACT

Five bulletins of the National Center for Clinical Infant Programs provide articles with the following titles and authors: "Motor Control as a Resource for Adaptive Coping" (G. Gordon Williamson et al.); "Fostering Emotional and Social Development in Infants with Disabilities" (Stanley Greenspan); "Dramatic Responses in a Safe Space: Helping Parents to Reach Difficult Babies" (Victor Bernstein); "Standards of Practice and the Pain of Premature Infants" (Jill Lawson); "Comfort Measures for Infant Pain" (Rosemary Campos); "Managing Pain in Young Children: A Pediatrician's Perspective" (David Howell); "Conceptualizing Screening Models for Developmentally Disabled and High Risk Children and Their Families" (Thomas Kochanek); "Infants in Institutions Revisited" (Sally Provence); "The Infant and Toddler Therapeutic Shelter: A Secure Base" (Sheila Anderson); "Transitional Group Homes for Children with HIV: Support for Children, Families, and Foster Parents" (Michele Granger et al.); "Forming Human Connections in Shelters for Homeless Women and Children" (Nancy Boxill); "The Professional Use of Self in Prevention" (Judith Bertacchi and Julie Coplon); "Recurring Questions for Family Support Practitioners" (Marilyn Segal et al.); "The Effectiveness of a Feeding Support Group as an Adjunct to Other Therapies in an Early Intervention Program" (Lisa Ingelfinger Harris); "Parent Training from the Speech-Language Pathologist's Perspective: A Case Study" (Sherri Coughlin et al.); "Drug Exposed Babies: Research and Clinical Issues" (Donna Weston et al.); "The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research" (Judy Howard et al.); "Serving Drug-Involved Families with HIV Infection in the Community" (Geneva Woodruff et al.); and "Promoting the Health and Development of Drug-Exposed Infants through a Comprehensive Clinic Model" (Barbara Tittle and Nika St. Claire). (DB)

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Zero to Three
Bulletin of
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Motor Control as a Resource for Adaptive Coping

by
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What really makes a difference in a child's life? Is it the acquisition of developmental skills? Or is it the ability to apply the skills so that the child can manage the challenges of daily living? Certainly achievement of object permanence, a pincer grasp, or any other skill is very important. However, positive meaning is not generated by a developmental skill per se but by its impact on the child's ability to cope.

It is generally agreed that learning and development take place within the context of a child's transactions with the environment (Sameroff, 1982). This complex process has several components. A transaction may start with an external or internal demand, the child then makes an effort to meet the demand, the environment responds to the child's effort, and lastly the child reacts to the environment's response. Transactions, which are so critical for functioning, provide a structure for intervention planning for infants with special needs (Williamson & Zeitlin, in press).

This article highlights one critical developmental domain, motor control, and how it contributes to an infant's emerging adaptive competence. The development of coordinated movement during infancy is described as well as the vulnerability generated by the atypical motor patterns often observed in infants who are developmentally delayed or disabled. To support the importance of coping as a focus for intervention, a study is summarized that compares the coping characteristics of disabled and nondisabled children under three years of age. Intervention options are presented that are based on the transactional process. They serve as a guide for designing intervention to enhance motor control and adaptive coping. A case study of an infant with Down syndrome illustrates the application of these intervention options in clinical practice.

JOHN DAVID ARMS

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Acquisition of motor control in infancy

One of the most crucial achievements of the infant during the first year of life is to establish a relationship with Mother Nature—that is, Gravity. An infant is born with all of the basic movements. The young child can extend (straighten), flex (bend), move laterally (side-to-side), and rotate (twist or turn). However, two important elements are missing: (1) the *postural control* necessary to assume increasingly advanced developmental positions against gravity, and (2) the *coordination* to use a wide variety of movement patterns in order to accomplish a task (Gilfoyle, Grady, & Moore, 1981). Thus, a challenge to the infant is to develop the control of posture and movement that enables the child to discover the world and manage it successfully.

> *An infant is born with all of the basic movements but must develop postural control and coordination of movement in order to discover the world and manage it successfully.*

The development of postural control against gravity procedes in a cephalo to caudal direction (i.e., from the head toward the feet). In this process, the infant acquires coordination of movement in a predictable sequence—extension, flexion, lateral movement, and rotation (Bly, 1983; Williamson, 1981). The acquisition of this control expands the child's repertoire of available coping strategies. As the infant starts developing control of extension against gravity, it is quickly counterbalanced with emerging control of the opposite movement pattern of flexion. Only when extensor and flexor movements are coordinated together does the infant demonstrate organization of lateral movements that allow weight-shifting of the body side-to-side. Rotation is the most sophisticated movement pattern and is therefore the last to be mastered in infancy.

During play the infant practices these movements and learns to organize them for functional use. When observing an infant during the first year of life, you can readily see the head-to-foot development of controlled extension when the infant is in the prone-lying position. At 1 month of age, the child rests in a curled posture when lying on the abdomen and has the arms tucked under the body. By 2 to 3 months of age, however, control of extension progresses to the mid-back, enabling the infant to lift the head and chest off the mat and bring the arms out to the side of the body. Gradually extension progresses to the low back, allowing the infant to use extensor muscles to raise the buttocks off the mat (the playful "bottom-lifting" of the 4-month old child). Around 5 to 6 months extensor control crosses the hips so that the legs come into alignment with the body and are no longer in a flexed posture to the side (the "frog legged" position). The infant celebrates this achievement by joyous rocking on the belly for countless hours. At approximately 7 months of age, the infant has conquered gravity in the prone position and displays controlled extension throughout the body (the Landau reaction).

Concurrent with the development of extension, the infant is acquiring control of flexion. It can best be seen when the child is in the supine-lying position. When resting on the back, the 2-month-old infant assumes an asymmetrical posture with the head usually to one side. During the next month, the infant learns to

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maintain the head in the body's midline due to developing coordination of the flexor muscles of the neck. This emerging flexor control becomes dramatically expressed in the symmetrical, midline-oriented play of the 4-month-old infant. The child enjoys bringing the arms together in order to pluck on clothing, mouth objects, and touch the bottle or breast during feeding. All of these activities contribute to sensory, cognitive, and emotional development and rely on the infant's expanding flexor skills. By 5 months of age, the infant engages in more body-oriented play by bringing the hands to the knees and lifting the head off the mat to look at the body. Greater control of flexion in the trunk (torso) and legs allows the infant of 6 to 7 months to grasp the feet, suck on the toes, and rock with delight in this flexed posture. Thus, the child has mastered gravity in the supine position and has an enhanced sensorimotor foundation for exploring the world.

When movements of extension and flexion are counterbalanced, lateral control appears. Around 4 months, the infant begins to right the head laterally in space when the body is tilted to one side during caregiving activities such as bathing or dressing. At this time, the child has adequate lateral control of the trunk to play in a side-lying position and not fall onto the abdomen or back. During the next few months, the infant learns to shift weight side-to-side when propping on the forearms or extended arms in the prone position. This ability to weight-shift laterally allows the child to free one hand to reach for objects. It also facilitates social interaction since the infant can attend more directly to the surroundings. By 7 months of age, the infant has sufficient control of lateral movements to "pivot on the belly" in a circle during play.

Many infants who are developmentally delayed, disabled, or at risk become blocked in their development of functional movement and thus limited in their ability to explore and learn.

The emergence of controlled rotation of the head, trunk, and extremities is founded on the development of extension, flexion, and lateral movement. Therefore, it is the most difficult movement pattern for the infant to coordinate. Rotation is usually associated in the early months with reaching or kicking. As the infant reaches for an object, the upper trunk tends to twist in order to support the movement of the arm. Likewise, kicking of the legs often elicits rotation in the lower trunk. These activities generally introduce early rolling. The infant reaches across the body when on the back, loses balance, and flips over. With practice, the child learns to roll with controlled rotation (i.e., the head turns, the shoulders follow, then the trunk, and finally the pelvis).

In large part, it is trunk rotation that enables an infant to assume new positions such as sitting, crawling, or standing and to move with balance from one position to another. In every new position, the infant must learn to coordinate extension, flexion, lateral movement, and rotation in order to locomote normally in that posture (e.g., reciprocal crawling, walking). The acquisition of motor skills is based on the infant's ability to organize the movements available at birth into increasingly sophisticated adaptive movement strategies.

Editors' note:

In this issue of *Zero to Three*, **G. Gordon Williamson, Stanley Greenspan** and **Victor Bernstein,** schooled in the disciplines of occupational therapy, child psychiatry and psychology, describe what they have learned by getting down on the floor and playing with special needs babies. They draw on years of clinical and research experience to explore the intricate connections between motor and emotional development in the early years of life and suggest strategies that parents and professionals can use to help very young children overcome challenges to adaptive development.

It is striking that each of these authors not only encourages caregivers to attend to the development of the *whole* child, but has himself reached beyond the traditional knowledge base of his own field, to learn from and collaborate with colleagues in other disciplines. It is also striking to see each author remind us that there can be joy for infants in mastery, and delight for babies and parents in being together.

"It is human nature to pursue what feels good," notes Victor Bernstein. We hope that readers will enjoy this issue.

Atypical motor development

Many infants who are developmentally delayed, disabled, or at risk have difficulty organizing the sensory and motor systems in a way that allows for successful interaction with objects and people. This vulnerability strongly influences their coping efforts. Frequently, they are born with low muscle tone and may have dysfunction in sensory processing. As a result, they become blocked in their development of functional movement (Bly, 1983). Generally, these infants start to develop extension but fail to counterbalance it with quality control of flexion. As a consequence, the more sophisticated lateral movements and those of rotation do not develop adequately (Scherzer & Tscharnuter, 1982; Williamson, 1987). Thus, they become limited in the movement patterns that are available for exploration and learning.

For instance, an infant with low muscle tone characteristically develops a predominance of extensor movement. There may be a tendency to pull the head and shoulders back with too much force. At the same time, the opposing flexor movements are slow to develop (such as reaching forward with the arms). With repetition, the atypical patterns of extension may become habitual and hinder further development. These extensor movements make it difficult for the infant to acquire head control, to suck appropriately on a nipple, to assume a good prone-on-elbows position, or to play with the hands together in sitting. Since balanced control of extension and flexion is not attained, lateral movements and rotation often fail to develop properly. Therefore, postural control and coordination are insufficient for the achievement of motor milestones. This clinical picture may interfere with the infant's acquisition of both the developmental skills and the adaptive behaviors necessary to cope effectively.

Coping behavior of infants with special needs

Motor control does not develop in a vacuum but within the context of a child learning to cope with daily activities. Movement becomes relevant when used to meet personal needs and to respond adaptively to the demands of the environment.

Shirley Zeitlin and I (1988) recently completed a study that investigated the coping characteristics of children between 4 and 36 months of age using the Early Coping Inventory. This new observation instrument assessed the coping-related behaviors that enable young children to manage the routines, opportunities, challenges, and frustrations encountered in daily living. The study examined the coping behaviors of 1035 developmentally delayed and disabled children and 405 normally developing children. Seventy-three day care and early intervention programs participated in the study from 22 states and Canada.

The results of this investigation support clinical impressions and previous research that suggest differences exist between the coping abilities of disabled and nondisabled children under 3 years of age (Cicchetti & Serafica, 1981; Krakow & Kopp, 1983; Wassermand, Allen, & Solomon, 1985). In this study, the disabled group was significantly less effective in their coping competence. As a group, their coping behaviors tended to be situationally effective. Behaviors used successfully in one type of situation were not generalized to other types of situations. Their coping behaviors were often erratic, rigid, or limited in range.

The greatest difference between the two groups was in their adaptive use of self-initiated coping strategies. The coping pattern of the disabled children tended to be less autonomous and self-generated. They were not as able to change behavior when necessary to solve a problem or achieve a goal, to enter new situations easily or cautiously as the occasion demands, and to balance independent behavior with necessary dependence on adults.

It is important to note, however, that in this study both sets of children included individuals with consistently effective coping behaviors and minimally effective behaviors. This finding suggests that the presence of a handicapping condition does not mean that a particular child will have maladaptive coping. Rather, it suggests a greater vulnerability to stress (Brinker & Lewis, 1982; Ramey, Beckman-Bell, & Gowen, 1980).

Regardless of the child's developmental level and type of handicapping condition, it is important for parents and professionals to encourage self-directed, purposeful behavior in a variety of situations. When this happens, the young child learns that intrinsically motivated behavior can be used effectively to generate successful outcomes (Dunst, Cushing, & Vance, 1985).

Intervention to enhance development and adaptive coping

Children cope most adaptively when there is a congruence between their coping resources and environmental demands and expectations (Lerner & East, 1984; Murphy & Moriarty, 1976). A goal of intervention is to encourage a "goodness-of-fit" between resources and demands so that the infant can manage daily living with a sense of well-being. In this process, the infant modifies previously learned coping strategies and develops new ones.

There are three primary intervention options that address the components of this transactional process. Each option is targeted to establish a better fit between the child and the environment. You can change demands to be congruent with the child's capabilities, change the child's efforts by expanding developmental skills and coping resources, or change the environment's response to the child's efforts. Due to the transactional nature of the coping process, all three intervention options are frequently used simultaneously (Williamson & Zeitlin, in press).

The first option, **changing demands,** requires active collaboration of parents and practitioners to ensure they have an adequate understanding of the child. This knowledge enables them to set expectations that match the child's ability to meet them. Specific intervention strategies include establishing appropriate goals, modifying demands when necessary, and grading stressors.

The second option, **enhancing developmental skills and coping resources,** increases the child's ability to implement effective coping efforts. Within the context of activities to foster developmental skills, the infant is helped to acquire more adaptive ways of coping. Direct and indirect intervention strategies facilitate this learning and are also used to generalize the skills for functional application in daily living. Some familiar direct strategies include modeling, reinforcement, and cueing. Common indirect strategies are structuring the environment and using supportive techniques (such as physical positioning of the child and adapted equipment).

The third option, **changing the environment's response to the child,** involves parents and professionals responding contingently to the child's efforts. Through this feedback, the child learns the impact of his or her behavior on the environment. When an effective coping effort receives positive and accurate feedback, both the infant and adult feel successful and experience pleasure in the interaction. Such reinforcement of adaptive coping leads to a sense of mastery that is usually reflected in subsequent coping efforts (Mahoney, Powell, Finnegan, Fors, & Wood, 1986).

The following case study provides sample illustrations of how these intervention options were implemented to foster the motor control and adaptive coping of an infant with special needs. An analysis of her coping resources (developmental status, coping style, and family support) helped to determine the goals and activities of intervention that promised to make the most functional difference.

Case study of Allison

Allison was a 7-month-old infant with Down syndrome who functioned developmentally around 5 months of age. She had low muscle tone which interfered with her ability to assume and maintain positions against gravity. Her development of extension was not balanced by controlled flexion. Therefore, she has little control of lateral movements and rotation. As a result, her posture was insecure, and use of her arms was restricted.

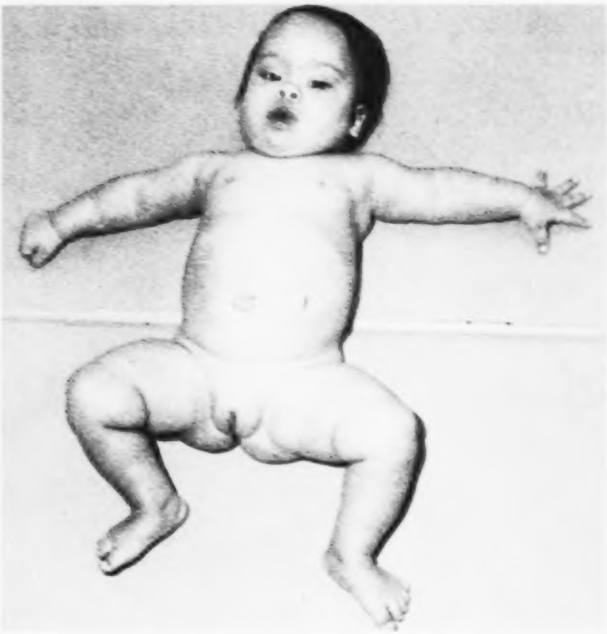

Figure 1

In the prone position, she was able to push up on extended arms for fleeting periods of time. However, she could not maintain the position, weight-shift to one side, and reach with one hand. As depicted in Figure 1, she was dominated by gravity when lying on her back. She did not have the anti-gravity flexor control to bring the hands together and to engage in body-oriented play with her legs. When placed in a sitting position, she could not reach forward independently to explore toys.

Her coping style was situationally effective. She had difficulty generalizing coping strategies to different types of situations. When the environment was structured to encourage adaptive behavior, Allison was successful. If not, she tended to assume a passive respondent role. Due in part to her constitutional characteristics, such as her low muscle tone, it was hard for her to initiate and sustain interactions. The struggle to maintain her posture against gravity seemed to deplete her energy. In these circumstances, she would typically withdraw or cry.

In order to plan intervention, it was important to identify the strengths and vulnerabilities of Allison's coping style. Her most adaptive behaviors were her visual and auditory interest in the surroundings, ability to react to the feelings and moods of others, and ability to accept warmth and support from familiar persons. Her least adaptive coping behaviors were her minimal effectiveness in initiating exploration of her own body and objects, difficulty in coordinating movement to be responsive to specific situations, and her passivity in trying new behaviors on her own.

Allison's family was most supportive and understood her emotional and developmental uniqueness. They were eager to adapt their caregiving in a way that fostered her development. The parents and I decided that one important goal for Allison was to develop the necessary motor control to support self-initiated exploration. The following sample activities were implemented to enhance her motor and coping competence. They illustrate use of common strategies that apply the intervention options for promoting effective transactions.

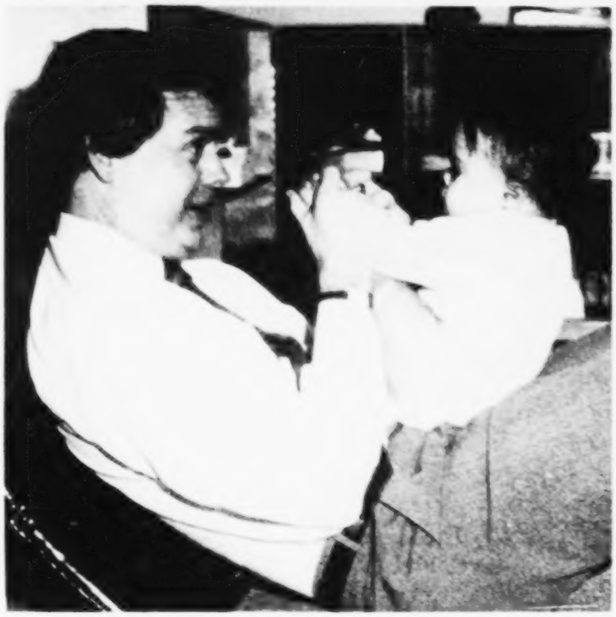

Figure 2

If Allison could improve her coordinated movement, she would be better able to engage in active exploration. Figures 2, 3, and 4 demonstrate an intervention sequence that I used to expand her control of flexion, lateral movements, and rotation respectively. I facilitated her efforts by emphasizing her coping strength of visual and auditory interest in social interaction. I continuously changed my physical position to ensure that our eye contact and social exchange helped Allison to organize her movements. As seen in Figure 2, we first played a foot-clapping game which required her to maintain flexor control of the head and trunk.

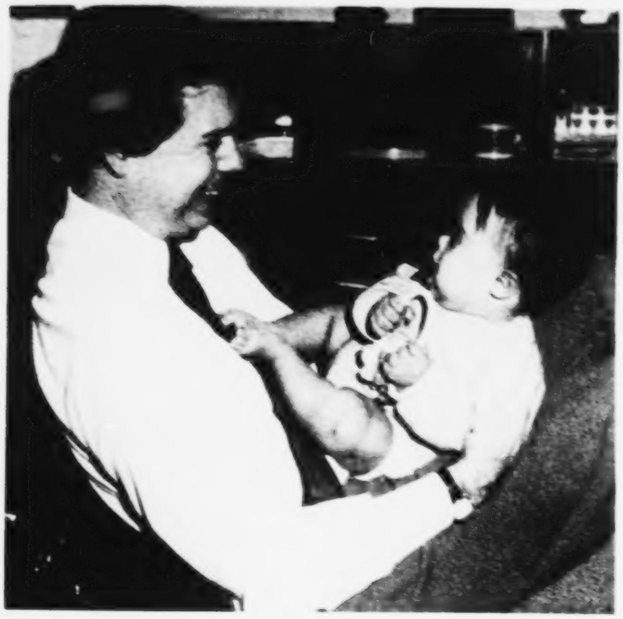

Figure 3

By capitalizing on her coping strength, I was able to increase my demands by progressing to a more difficult activity that required control of lateral movements (see Figure 3). In this case, I shifted her body to the side by lowering one of my legs and raising the other. She responded by laterally righting her head in order to maintain visual regard of my face. The task was repeated in the other direction so that she could experience lateral control of the head toward both sides. She was motorically successful because: (1) the activity was in a social context, (2) she could tolerate the weight-shifting of her body since it was smoothly translated through my lap, and (3) she held a toy which assisted her to stabilize the upper body.

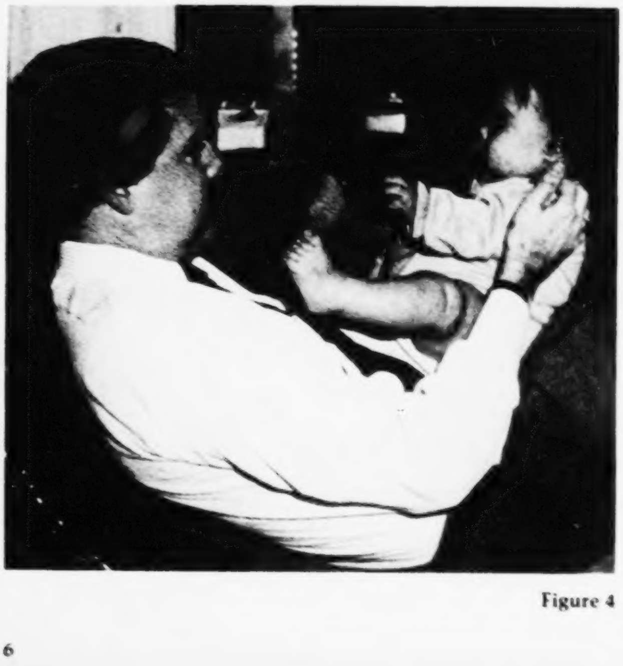

Figure 4

Based upon this success, I presented a game to encourage rotation of her trunk. She became intrigued by yarn that I placed on one foot, and she started to play with it. As illustrated in Figure 4, Allison was able to reach across her body and maintain the rotation of her trunk because I provided support at the shoulder. Next, she played with yarn placed on the other foot in order to experience rotation of the body in the other direction.

Variations of this intervention sequence were introduced in a naturalistic matter into caregiving activities in the home. For example, the parents were shown an easy way to diaper Allison that offered an opportunity to practice control of the desired movements and to begin exploring her legs. She soon developed sufficient coordination to enjoy body-oriented play on her own.

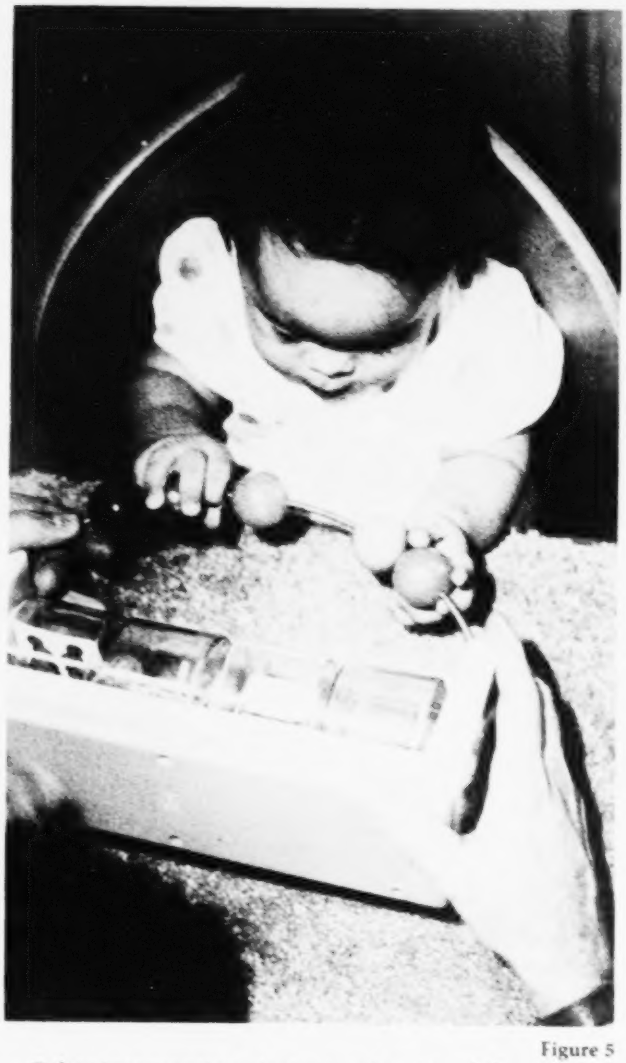

Figure 5

Other intervention strategies structured the physical environment to promote self-directed activity. Her side-lying position in the crib was modified so that she could employ lateral control to maintain the posture and not arch onto her back. A pillow was placed under her head, and another partially supported her back. With these adaptations she was able to bring the hands together to manipulate toys.

In addition, a special chair was used that stabilized her sitting position and guided her arms forward for reaching (see Figure 5). A variety of toys was selected that encouraged Allison to expand her play schemes with objects. In this case, any slight lateral movement of the arms caused the balls to travel on the track. Over time she learned to bang the balls together and flip them vigorously from side-to-side. Thus, the physical environment assisted her motor coordination and provided contingent sensory feedback to her self-generated efforts.

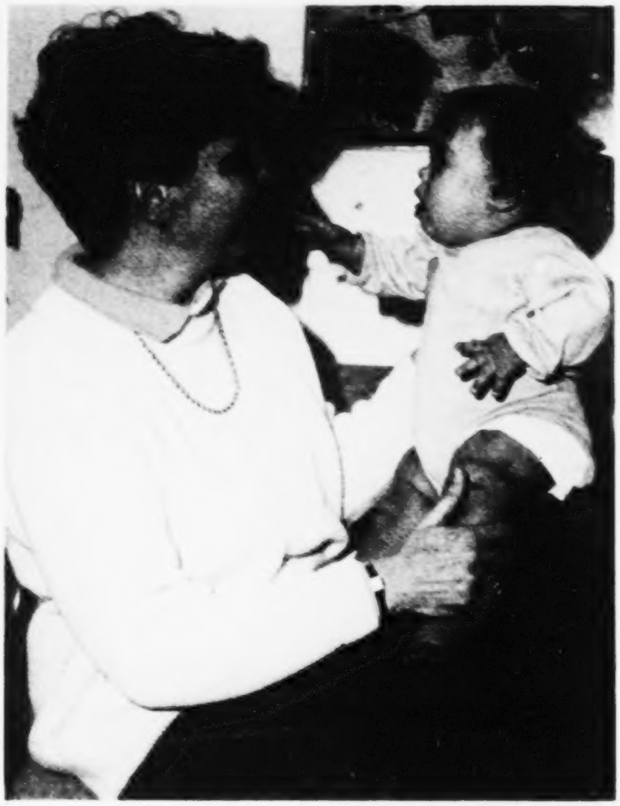

Figure 6

The mother was interested in finding a way to position her daughter on her lap so that Allison could be more active when they played together. Due to the child's low muscle tone, she was usually held cradled in a reclined position. In this posture she tended to be passive. The mother laughingly said that "Allison is becoming a couch potato!" Figure 6 demonstrates one position that was devised to address this issue. Allison sat on her mother's crossed legs with slight support provided to the trunk by the mother's hand. In this position they faced each other on the same eye level, and Allison was able to reach independently to touch her mother's face and clothes. Thus, the position fostered social interaction, communication, and motor expression.

In conclusion, a child's motor control serves as a major resource for supporting coping efforts. The development of controlled movement and posture expands the repertoire of coping strategies that the infant can use to manage daily living and to master new learning. When planning for infants with motor problems, intervention is designed within a transactional context to ensure that the acquisition of developmental skills results in functional outcomes.

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Fostering Emotional and Social Development in Infants with Disabilities*

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Infants, like all human beings, do things, at least in part, to satisfy emotional and social needs and goals. As infants develop, they want to be close to another person, to experience pleasure and excitement, to be intentional by making things happen, to be assertive and curious, and to receive responses to and confirmation of their own inclinations. These basic emotional experiences are a foundation for motivation and mastery.

Most infants with developmental disorders or delays are capable of progressing through adaptive stages of emotional and social development, but research and clinical practice teach us that such progress cannot be taken for granted. To surmount the challenges to reaching their emotional potential and achieving robust relationships within the family and in the outside world, infants with disabilities or delays may need special patterns of care. Many babies with special needs now receive therapy designed to remediate motor delays, language delays, cognitive lags or sensory processing difficulties. But the social and emotional aspects of development are at least partially ignored in such work. This article represents an effort to help professionals who work with infants and toddlers with disabilities and with their families attend to the stage-specific emotional needs of these children along with their physical and intellectual needs. Professionals and parents can then work together to provide experiences that will promote adaptive emotional patterns in the context not only of changing emotional needs, but of individual differences in infants and families as well.

We will discuss: 1) adaptive and maladaptive patterns of emotional development in the first three years of life, with special attention to the challenges presented by disabilities; 2) domains of experience that help all children achieve their emotional milestones; 3) new pilot research findings comparing the emotional interaction of handicapped and non-handicapped infants and their families; 4) clinical principles to guide an integrated approach to sensory, motor, cognitive and affective challenges confronting infants and toddlers; and 5) implications for effective alliances among the infant the family and the service system.

Overcoming barriers to emotional growth: preventive therapeutic approaches

In a number of publications for professional and general audiences (Greenspan, 1981, 1987; Greenspan and Lourie, 1981; Greenspan and Porges, 1984; Greenspan and Lieberman, 1980; Greenspan and Greenspan, 1985; Greenspan and Greenspan, in press), we have formulated the emotional milestones of the first three to four years of life and the related principles of preventive intervention. The emotional milestones are: 1) regulation and interest in the world; 2) formation of a human attachment; 3) purposeful communication; 4) a complex sense of self; 5) creating ideas; and 6) emotional thinking. At each of these stages a child's development may be adaptive, or development may be compromised in varying degrees, resulting in diminished range, depth and/or stability of emotional experience and expression or in a limited emergence of personal uniqueness. Various types of developmental delays or disabilities pose challenges to the attainment of specific emotional milestones. Special patterns of care, however, may help the infant or young child surmount these obstacles to emotional growth.

Most infants with developmental disorders or delays are capable of progressing through adaptive stages of emotional and social development, but they may need special patterns of care to surmount the obstacles to reaching their potential.

Regulation: If the infant's internal states are regulated harmoniously, she is free to invest herself in both the inanimate and animate world, thereby setting the basis for rich emotional attachments to primary caregivers. But if regulatory processes are not functioning properly and the infant is either hypo- or hypersensitive to sensations, she may achieve a less than optimally adaptive structural organization even in the first months of life. A relatively minor difficulty at this stage would be a tendency to withdraw and/or become hyperexcitable under stress; a major deviation from adaptive development would be an infant's overwhelming avoidance of the human world.

Central nervous system immaturity may render infants over- or under-sensitive to the routine tactile, vestibular, auditory or visual experience that most babies enjoy. Caregivers need to find types of experience that will comfort sensitive infants and gain the interest of under-reactive infants. For example, firm holding and pressure may be helpful for the infant who is overly sensitive to touch. On occasion, the use of large muscle groups in helping an infant pull from a sitting to a standing position in one's lap, combined with special patterns of visual and auditory experience, may enable the child to attend more effectively.

If motor coordination difficulties prevent an infant from getting his hand to his mouth or exercising the control over body position expected at his age, he will be less able to comfort himself. Integrating special patterns of holding and movement in space are

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therefore important to facilitate the infant's comfort, regulation, and interest in the world.

Feeding difficulties may be associated with either low muscle tone (e.g., difficulty swallowing) or high muscle tone (e.g., tongue thrust pushing fluid or food out of the mouth). Such problems interfere with an important early source of pleasure for most babies. They also interfere with patterns of regulation, and with the use of feeding as one element in a mutually satisfying relationship between infant and caregiver.

Attachment: Early attachments can be warm and enjoyable or shallow, insecure and limited in their affective tone. A motorically delayed infant may lack some of the tools most babies use to express joy in the presence of a caregiver. The caregiver will need to look beyond poorly coordinated motor responses, lack of synchronous vocalizations, and difficulty in organizing even a smile, until she finds a special look or gesture of pleasure unique to her infant, and can respond. Otherwise, the infant is likely to become doubly frustrated when he cannot control his own body and, because of this, form joint patterns of joy with the people most important to him.

Purposeful communication: At this stage, the ability to integrate sensory experiences across the senses (e.g., auditory and visual); to connect sensory and motor experiences (e.g., looking and reaching); and to plan and implement motor activities in accord with adaptive goals (e.g., exploring mother's mouth) are all important elements in learning to communicate purposefully, to take the initiative, and to make things happen in the world. It is also important at this stage for an infant to be able to communicate purposefully across the whole range of emotions (e.g., reaching out for physical and emotional closeness, curiously exploring Dad's nose, or throwing down food in angry protest), and to use all the sensory realms in support of emotional interaction.

Infants with compromised motor tone, motor planning, sensory discrimination, cross-sensory integration, or sensory motor coordination will require special help in mastering this crucial emotional and cognitive stage; otherwise infants may confuse already anxious caregivers, and patterns of withdrawal, overcontrol and/or chaotic or disorganized interactions may replace purposeful ones. For example, the infant with low tone may enjoy being catered to and may elicit overprotective patterns and overcontrolling (and at times even overstimulation). The high energy, increased motor tone, distractible infant may find himself caught up in a confusing array of random responses from parents who are trying to keep up with his pace. In both these circumstances parents require help in reading and responding to specific cues so that their infant learns to communicate in an organized and intentional manner. This is an especially important time to work with attention and focus. Finding the most appropriate pattern of calming and combining it with carfully modulated sensory-affective experiences (rhythmic vocalizations and facial expressions) can help the distractible baby or the seemingly inward looking baby increase his attention span from 1-2 seconds to 3 seconds, then 6 seconds, and eventually a number of minutes. Helping an infant develop the first 3-6 second attention span can be a caregiver's hardest but most important task. Babies need to attend for this length of time at a minimum if they are to develop a *self-sustaining* interest in their environment.

Complex sense of self: Toddlers who are becoming behaviorally more organized demonstrate their increasingly complex sense of self through emotional patterns which reflect originality and initiative in the context of the separation and individuation subphase of development (Mahler, 1975). Children developing less adaptively may appear stereotyped in their behavior patterns, reflecting no originality or intentionality. Their behavior may remain fragmented, rather than connected into complicated sequences. They may lack the capacity to integrate emotions as illustrated by the chronically negativistic, aggressive toddler who cannot show interest, curiosity or love.

At a time when he is struggling to balance his needs for independence and dependence, the toddler who is motorically delayed may lack a sense of control over his own body and over space. Experimenting with the large muscle activity associated with assertiveness and aggression may prove frightening, leading to avoidance of these important domains of emotional life. Self care activities like dressing or bathing may prove frustrating for both child and parent, as the child may learn to use arching, fisting or stiffening of the extremities to avoid these challenging experiences. A toddler with sensory processing lags faces her own special challenges in experimenting with independence. If it is difficult to discriminate auditory and visual cues across space (e.g., staying in emotional touch with a parent from across the room, by decoding the parent's vocalizations and gestures), a child may need to rely on proximal forms of reassurance (e.g., being held), or may become frightened easily.

Unique caregiving approaches that may help children with disabilities to organize and integrate behavioral and emotional patterns include working on increasing attention and focus, adding one more piece of behavior to an ever-growing complex pattern of interaction; supporting assertiveness through extreme patience in letting a toddler repeat motor gestures and acts for himself, providing only extra vocal and visual support; and working on communication accross space by reading and responding to visual and auditory gestures.

Creating ideas and emotional thinking: Adaptive development at this stage includes the ability to integrate across sensory, emotional and motor experiences; to practice using ideas through "pretend play" and language; to distinguish the self from the nonself; and to express emotions intentionally in language (e.g., "I am mad.") Compromised development is observable in the child with deficits in imaginative play and communication, reality testing, impulse control or focused concentration, or in the child who withdraws from or is chaotic or disorganized in relationships.

In order to negotiate the emotional tasks of early life successfully, all children need experiences in the caregiving environment that support emotional growth.

Motor delays or athetoid movement patterns may compromise a child's ability to engage in make-believe play, employ functional language, or regulate affect. Sensory integration or sensory-motor coordination lags also create special challenges for the child and her caregivers to find new ways to create and to practice using emotional ideas. For example, the pre-schooler with an auditory-verbal processing (receptive language) difficulty, if very creative, may begin "marching to the beat of her own drummer" because it is easier to communicate with herself than to figure out the sounds and words of someone else. In such a circumstance it is iimportant to help the child take in and use the other person's information (e.g. "closing the circle"—to be discussed later).

Domains of experience that foster emotional development

As our discussion of the six emotional milestones suggests, the process of emotional growth takes place, for all children, in the context of a caregiving environment. It has been useful for us to identify four domains of experience that can be extrapolated from the six milestones and that cross age ranges and stages. All children need these for successful negotiation of the emotional tasks of early life.

Attention and engagement make up the first domain of experience. Attention and engagement mean face-to-face contact, a sense of connectedness, and shared attention between the infant and another person, in a context of warm, pleasurable or loving feelings. The developing infant elaborates a range of emotional inclinations, providing a context for attention and engagement. For example an eight-month-old elaborating an inclination for dependency can gesture for closeness by reaching out to be picked up. She can also be assertive, using motor control to put her hand in Mommy's mouth or to squeeze Daddy's nose. She can already experiment with anger by knocking the food off the table if she doesn't like dinner, or she can make angry vocalizations. She can elaborate pleasure and excitement by touching her own body or by creating tactile contact with Mommy or Daddy.

The first question caregivers must ask is: Are we helping the child engage, and if so are we helping the child to engage in the full human drama? How is the child letting us know about dependency, assertiveness, anger, pleasure and excitement? Many parents are comfortable with one domain of engagement but not with others. Pleasure may be comfortable, but anger is not acceptable. Or assertiveness is encouraged, but too much closeness and dependency seem frightening. We must ask ourselves if we are helping a child to feel connected in terms of his *own* inner life. At the stage of emotional ideas, this will mean learning to elevate inner sensations to the level of emotional ideas, rather than simply to inhibit them. With the eight-month-old we have the opportunity to engage behaviorally. With the three-and-a half year old we have the opportunity to engage through words and pretend play.

Children with handicaps for example, often have not been engaged around aggression. Later, as 8 and 9 year-olds, they may be afraid of aggression because these sensations have never graduated from the "body" or behavioral level to the ideational level, where they can be reasoned about. Because such children lack the sense of security that emerges from an ability to reason out and control their anger, they are afraid of it: they may become passive, diffusely passive/aggressive, or diffusely aggressive.

Crucial domains of experience include: 1) attention and engagement; 2) intentional, reciprocal gestures and cues; 3) elaboration of behavior and feelings into higher forms; and 4) categorization of experience.

Intentional, reciprocal gestures and cues constitute the second domain of experience essential for all children. Even before words or other symbols become important or even useful to a child, he organizes his world, and his sense of preverbal reality, in the context of an organized gestural system of communication. The most basic emotional messages of life, dealing with safety vs. danger, acceptance vs. rejection, approval vs. disapproval, respect vs. disrespect for uniqueness, and support and pride in, vs. undermining of, an evolving sense of self and its emotional inclinations, are communicated back and forth between the child and his caregiver through movements and movement patterns, gesture, facial expression (including emotional expression), vocal tone and rhythm, and combinations of these. To the degree that there is an organized, intentional give and take of information, the child "figures out" his preverbal, presymbolic world and has a secure foundation for moving ahead. When this gestural system is not mastered and later symbolic modes need to be used consciously to "figure out" issues of safety and acceptance, it is easy to imagine from one's own adult perspective how such preoccupation may leave little energy for new learning.

Communicating preverbally, with movements, will require special practice by young children experiencing motor difficulties. Visual, spatial and/or auditory-vocal processing difficulties will pose challenges to infants trying to interpret the cues of others.

Elaboration of behavior and feelings into higher forms, with a special focus on "ideas" or representations is a domain of experience between the young child and a caregiver that seems essential if the child is to become able to create ideas and engage in emotional thinking on his own. While the ability to create ideas appears to begin at 18-24 months with language development, the ability to abstract and organize information at higher and higher levels is a gradual and continuing process. Between ages 1½ and 2½, special pretend play times or "floor time" often provides the context for these types of interactions. Such play times, where dolls or soldiers may carry forth the emotional theme, may demand a great deal from caregivers. As with the experience of attention and engagement, caregivers need to understand their own emotional reactions to the child's expressions of dependency, aggression or grief. Helping a child bring the "full human drama" to the world of ideas is not easy to do but represents a priceless gift.

Categorization of experience: Differentiating experience along a number of dimensions (the most basic distinction being between the self and the non-self) forms the basis for a stable sense of reality, the ability to accept responsibility for one's actions and to control impulses, and the modulation and integration of thought and feeling. Children need experiences of responses from the environment that are logical and realistic, flexible, highly individualistic, and timely. The parent who can respond differentially and appropriately to subtle differences in the child's verbal, emotional or facial expression that suggest playful teasing, serious teasing, a careless request, a serious demand, mild competition, serious competition, mild curiosity, assertive curiosity, etc., will encourage the differentiation and consolidation of the child's emerging categorization of experience. The child's ability to categorize both emotional and impersonal experience is the foundation of his basic personality functions.

In addition to these four domains of experience, children with disabilities require special types of experience to promote emotional and social growth.

One such experience I call *closing the circle.* Consider a bright, creative three-and-a-half year old with auditory-verbal processing difficulty. He is inattentive and "marches to the beat of his own drummer." He may play out a nice pretend sequence in which he will have a rocketship going off in space. Mother will say, "Gee, it looks like your rocketship is going to the moon." The child will say, "Look at this horse here. The horse is going in the rocketship." And Mother will say, "Oh, we're going to take the horse to the moon?" and he'll say, "Look at this cow here." And Mother will say, "Oh, is the cow coming to the moon, too?" and then he will say, "Look at this truck." He is verbally creative, but he never takes in what Mother says and builds on it. As one plays with a child like this, one realizes that the child is not "closing the circle," building on what one says. The play is not really interactive, although it looks interactive. The child is relating warmly, but he is not using the other person's information. Even in conversations, there is lots of eye contact and warmth but no real interactive elaboration or logic.

Helping children to close circles helps their differentiation. One way to do this is to respect what is said—for example, "I see the cow, but you're ignoring my moon. What about my poor moon here?" If the child says, "Shut up about your moon," he is still closing the circle, because he has responded to the other's information. Circles can also be closed at the level of gestures and behavior, where chains of behavioral interactions build on one another. The caregiver of a motorically delayed infant for example, will need to be especially alert to even slight vocal or motor signals for interaction so that they can be quickly interpreted and responded to in a phase-appropriate manner. A seemingly disorganized slap on the nose during the "nuzzle dance" may provide the opportunity for Daddy to be a "honk, honk" car, encouraging these touches to his nose with his novel and entertaining "honks". Here, Daddy is simultaneously providing movement, touch, head, shoulder, and trunk support, and wooing (in a loving way), and cause-and-effect feedback for emerging motor patterns.

Another area of experience concerns *limit setting*. Adults have a tendency to avoid setting limits with handicapped children. Limits should always be gestural or verbal, understandable, negotiated, and reinforced as needed with discipline. Without limits chidren do not feel safe vis a vis their own anger. The key is always to increase engagement, interaction, "floor time" and closing of circles together with limits. Too often, as we increase the limit setting, we disengage. Whenever we increase limits we must increase engagement and spontaneous communication, either through pretend play or through behavioral, social and emotional interaction.

Emotional interactions between handicapped and non-handicapped infants and their parents

We have described stages of emotional development during the first three years of life and suggested the challenges to achieving emotional milestones confronted by infants and toddlers with various handicapping condition. We have also described some of the interactive experiences that seem to be essential to all children in negotiating the tasks of emotional growth in the early years.

How do the emotional experiences of infants with handicaps compare with those of non-handicapped babies? In a preliminary study to explore this question, G. Gordon Williamson, Shirley Zeitlin, Serena Weider, Suzy Poisson and I observed ten motorically handicapped infants and ten motorically competent infants in interaction with their parents. We matched the groups for motor age. For example, a fifteen-month-old infant who was functioning at a motoric level of seven months was compared emotionally to a seven-month-old baby without a motor handicap. A fifteen-month-old with a handicap would therefore only need to do as well in emotional interaction as a seven-month-old for there to be no difference in the rating between the two of them.

The results of the pilot study provide preliminary support for our clinical impressions. Presumed motorically competent babies were involved in social engagement with their parents 43 percent of the time observed. But parents and their handicapped infants were socially engaged only 18 percent of the time. Motorically competent babies and their parents were more contingent (they read each other's signals) than handicapped babies and their parents. Anticontingent (negative) responses were more frequent in the handicapped group. Overcontrolling, intrusive, or opposite-from-expected responses by parents were three times as frequent in the handicapped group as in the motorically competent group. We also saw more nonparticipating, noncontingent, or withdrawn responses in the parents of the handicapped infants. In addition, handicapped infants tended to be more negative to their parents.

It is important to note that the group of motorically handicapped infants was just as capable of sending emotional social signals as the motorically competent group. These children made opportunities to interact available to their parents just as the motorically competent babies did. They experienced, however, more missed opportunities and more misreading of signals.

Perhaps these trends should not be surprising. Perhaps the expectable and even natural response of many parents to a baby who is not giving an easily read signal is either to shut down or to withdraw. But infants will in turn become negative, disorganized or withdrawn if their partners are not offering interactive opportunities.

The following principles may offer both professionals and parents guidelines for using their encounters with handicapped infants as opportunities to encourage emotional and social, as well as physical and cognitive, growth.

Clinical principles of an integrated approach to sensory, motor, cognitive and affective challenges

At each stage of emotional development, specific sensory or motor challenges will create unique emotional challenges as well. Fortunately, there are many ways for an infant to learn to be regulated, to relate to others, to communicate intentionally, to form a complex self, and to use emotional ideas to guide bahavior and feelings and to categorize experience. The question then becomes: how do we turn each challenge into a unique learning opportunity? For example, how do we help the infant with increased motor tone to correct the motor difficulty and, at the same time, learn to use his motor system for "falling in love," cause and effect emotional signaling, emotional thinking, and so forth? In considering the objective of integrating the child's physical and emotional needs, a key guiding principle immediately suggests itself.

Principle I - Each activity aimed at improving sensory, motor, or cognitive capacities should also have, as its goal, facilitation of the relevant, age-expected emotional pattern.

For example, the traditional approach to working with an 8-month-old with motor lags and increased motor tone would involve the use of positioning and handling techniques to normalize tone and to facilitate normal

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patterns of movement (i.e., mobilization of trunk, rotation patterns, and use of weight shifts and weight bearing posture). One might position an 8-month-old infant with poor head control prone over a bolster so that the arms are in a forward position while rotating the trunk and shoulder girdle to mobilize the spine.

How does one at the same time create an opportunity for the emotional task of learning cause-and-effect emotional signaling? One might work toward teaching the infant to imitate simple movements of the hands (e.g., touching pictures, touching facial parts—"I do it; now, you do it.") One might help the infant learn an emotional, relevant, intentional gesture indicating dependency (e.g., reaching up to be held.) To be sure, a complex motor gesture would be shaped through gradual approximations. But if each approximation, and eventually the complete pattern, was emotionally age-appropriate and relevant, and was responded to with a great deal of physical and emotional warmth ("that's great, I love you"—with a big hug), the infant would be learning in his own way to make things happen in the emotional world of closeness and dependency. He would learn "I can communicate my desire for closeness," rather than learning that closeness is random and the best he can do is remain passive or fragmented. As this example indicates, there are two parts to learning: 1) helping the child organize emotionally and socially relevant patterns, and 2) responding to each step in the sequence of the newly learned pattern in a pleasurable manner. Therefore, Principle II is:

> *Principle II* – *Each emotionally or socially relevant pattern, either in its incipient stages or in its complete form, should receive a timely, "phase-specific," pleasurable, emotional response. This includes the caregiver's position (i.e., when possible, in front of infant) and affective disposition (i.e., you can't fake pleasure).*

The fact that the caregiver's response should be developmentally phase-appropriate is illustrated by the motorically delayed 15-month-old who manages to crawl away from his caregiver and looks back with a smile of accomplishment. Clapping and admiring the infants' accomplishment from afar with distal communication support, i.e., affective verbal and motor gestures, may at that moment be more phase-appropriate than a big hug and cuddle. This infant is learning to balance dependence and independence, and communicating across space with word and gesture. Distal communication modes, such as the use of words and gestures, support the infant's emerging ability to "be close" from across space. Because some motor exercises are carried out from behind the infant or child, to facilitate purposeful communication, innovative approaches will need to be developed to arrange for flexible enough positioning for appropriate, fact-to-face, emotional interactions. A part of an infant's emerging communication capacities is his interest in self-control and initiative, leading to another principle.

Principle III - Each emotionally relavant interaction should facilitate self-initiative (in generating similar emotional patterns) and the generalization (and abstraction) of these patterns to all areas and contexts of functioning.

In facilitating phase-specific emotional patterns, one should always ask, "am I doing it *for* the child, or am I creating a learning opportunity where he is learning to take intitiative?" The 9-month-old who hears a "toot, toot" every time he presses his hand near his father's face, is learning to take initiative and make things happen. In contrast, the 9-month-old who is only read to is learning to receive information passively. The application of a new emotional skill to multiple contexts, (e.g., touching Daddy's face to make Daddy say "toot, toot;" pulling Mommy's finger to get her to stick out her tongue; exploring the various ways G.I. Joe can "destroy the bad guys") facilitates the application of emotional-behavioral patterns and emotional-ideational patterns (through pretend play) to multiple contexts.

In addition to the challenge of learning to take initiative and generalize new coping capacities, the infant or child with developmental disabilities, as well as the infant or child with cognitive lags or difficulties, faces another important challenge. This challenge relates to the critical psychological task of differentiating an emotional sense of self which is unique, encompasses the full range of human emotions, and is clearly separate from one's sense of others and non-self. Children with difficulties in sensory processing often have difficulty in discriminating subtle aspects of sensory-affective experience (e.g., "Is she happy or sad?"; "Does he intend to hold me or hurt me?"; or "Am I angry or scared? Is my wish to bite a part of me?"). The child with tactile defensiveness and motor planning problems who bumps into another child may yell "Stop hurting me! Watch where you are going!" While such emotional interpretations relate to one's experience, a basic difficulty in discriminating incoming information or information arising from one's own body (e.g., somatic affective cues) because of discrimination problems would almost certainly make it particularly difficult to interpret confusing experience. Cognitive lags, involving limited ability to abstract, may contribute to a child's trouble with forming the difficult emotional aspects of one's self into an organized pattern. Similarly, motor planning or control difficulties would create an extra challenge in developing a secure sense of self in terms of body control, assertiveness, and handling aggression (e.g., "If I can't make my body do what I want it to, then what can I control, and where does my self-initiative and control end and someone else's begin?").

To facilitate a differentiated sense of self across the full range of human emotions in a child who has sensoryaffective discrimination, cognitive, motor planning, or control difficulties requires that special experiences be made available, leading to another principle.

Principle IV - To support and provide extra practice for self-differentiation. To accomplish this, provide extra opportunities for interpersonal interactions which have the elements of: 1) the infant or child elaborating the full range of human emotions and inclinations, including closeness or dependency, pleasure, assertiveness and curiosity, anger, protest, self-limit-setting, and, eventually, empathy and consistent love, and 2) caregiver responses which are clear and accurate in regard to the child's elaborations, including feedback which provides a sense of being understood and at the same time supports further self-initiated elaboration.

The caregiver will need to watch for any vocal or motor signals of pleasure from the baby in order to respond appropriately. A caregiver may encourage assertive exploration while a baby is secure in a bean bag chair, by making the adult's own body a multi-responsive human toy. The goal is to integrate the infant's need for increased motor tone and alertness, with sensory interest in the world, a loving attachment, and cause and effect emotional signaling. The preschooler may require extra practice in using "floor time" for pretend play and may also require extra patience to let him communicate themes of assertiveness and even anger alongside themes of dependency and closeness. The tendency to "do" and later play and talk and even "close circles" for the disabled child is enormous. Yet self-differentiation requires creating the empathetic and interactive context for the child to learn these on his own.

Understanding the milestones of emotional growth in the first years of life should facilitate, for both professionals and parents, attention to expectable, but nonetheless potentially undermining, interaction patterns, including resentment and over expectation early on, and over-protectiveness and inability to let the infant take initiative when capable later in development. The phase-specific emotional needs of the infant provide a context for the professional and parent to consider their own attitudes and expectations in relationship to the infants' emotional requirements.

The guiding principles we have discussed and illustrated are designed to provide a base from which innovative therapists and parents can develop their own unique ways of working with an individual child's physical and emotional experience. For example:

- A speech and language therapist may use pretend play to practice vocalizations, and at the same time focus on the child's phase-specific interests and fantasies (e.g., a 3½ year-old interested in how the different parts of the doll's body work).
- A parent may help her four-month-old, who is uninterested in being in the prone position, to roll over and tolerate the prone position, by combining it with pleasurable, face-to-face interactions.
- A health professional helping a parent of an irritable and crying 10-week-old may suggest that special postures, holding, and touching patterns be combined with extra practice in using distal communiation modes, including looking, listening, and gesturing, to facilitate an "organizing" interest in the world.

Elaborating principles, of course, is far easier than implementing them, especially when the goal is to help the child catch up emotionally, as well as motorically, and when one is trying to work at all the levels described above. Consider, for example, the nine-month-old infant with a severe motor lag and hypotonicity. Assume that the child's alertness, interest in the world, pleasure in others (a warm attachment), and intentional communication are compromised. In such a case, one is working to help the child stabilize head, shoulders, and trunk, and at the same time to provide enough tactile, vestibular, and other sensory input to facilitate increased tone, alertness and interest in the world. Here, the first goal is to find ways to encourage and maintain alertness to that the child can eventually create by himself those movement patterns and sensory experiences that support increased tone and alertness. At the same time, one is attempting to "woo" the infant so that he finds the human world especially lovable. A game of vigorous dance, nuzzling, and hugging may combine the beneficial effects of movement and touch with the warm, pleasurable emotions of being close.

The infant, the family and the service system

In order to help infants with disabilities attain important emotional milestones, professionals must understand the special challenges their families face. It is not unusual for a mother or father of an infant with a developmental disorder to go through a series of stages. Initially, parents may have a hard time accepting their infant ("he is not a part of me"). This may be followed quickly with a feeling of guilt and an overidentification ("he *is* me"), but if a parent feels negative about herself and her challenging infant, she may feel "she's a bad me." This stage also may last only a short time and be followed by a compensatory reaction, in which the parent will resolve to make herself and her infant perfect ("she is going to be a perfect me"). These attitudes are often associated with characteristic interaction patterns between parents and infants with disabilities. Withdrawal and apathy may be related to the feeling that the infant is not part of the family. Critical, intrusive, and even punitive behavior may be related to the feeling that the infant is part of a "bad me". Overprotectiveness, overcontrolling and undermining of autonomous behavior may go along with the "it will be a perfect me" attitude. A "perfect me" attitude may also mask only marginally a feeling that the infant is "inadequate without me" and lead to difficulties when the child tries to become more independent. As the child becomes more self-sufficient and competent, either abrupt withdrawal or depression and excessive fears about injury or illness befalling the child may, ironically, characterize caregiver behavior.

When parents' attitudes differ significantly from one another, marital conflict may result. Feelings about the challenging new infant may be so consuming that the parents have difficulty in being sensitive to each other's needs. In some instances, parents may feel so embarrassed about their "negative" private feelings that they may isolate themselves more and more from their spouse. Siblings (with worries about "will this happen to me, did my anger and jealousy do this to him, can *I* get love and attention by being sick?") and extended family members are often involved in these patterns, as well. Not infrequently, the infant with a developmental problem becomes the focus of unresolved family issues centering on dependency, anger, damage or loss. Lack of sleep, along with the expected physical and emotional stresses, may further compromise caregiver coping capacities.

It may be useful to view caregivers as faced with a number of general challenges, which include: 1) providing physical protection and care; 2) recognizing basic signals of pleasure and displeasure in the context of providing an ongoing sense of acceptance and love; and 3) understanding and responding to the stage-specific, emotional, intellectual, and physical requirements of their infant, in the context of their infant's individual differences and unique abilities. For each stage of development, caregivers must understand their own emotional reactions in order to provide special experiences that are appropriate to the infant's unique characteristics. As we have described, infants and young children with disabilities may have difficulty returning their caregivers' "wooing" and may communicate emotionally in ways that are confusing rather than clear. Caregiver feelings of rejection, anger or confusion are to be expected, and must be understood and responded to in order for caregivers to remain engaged with and emotionally available to their children.

We must also recognize the special emotional challenges to service providers presented by infants and toddlers with disabilities and their families. Just as a caregiver may become "mechanical" with and emotionally distant from her chaotic and disorganized infant, the individual clinician or treatment team may become mechanical to avoid the intrusive, overanxious, disorganized caregiver or family. We have often observed a chain reaction in which the infant's special needs create a disequilibrium in the family (e.g., marital difficulties, alcoholism or psychosomatic problems),

Table 1

Emotional Milestones, Family and Service System Patterns

Stage-Specific Tasks and Capacities	*Infant Maladaptive*	*Family Maladaptive*	*Service System Maladaptive*	*Service System Adaptive*
Homeostasis (0-3 mo) (Regulation and interest in the world)	Unregulated (e.g., hyperexcitable) or withdrawn (apathetic) behavior	Unavailable, chaotic dangerous, abusive; hypo- or hyperstimulating; dull	Critical and punitive	Supply support structure and extra nurturing
Attachment (2-7 mo) (Falling in love)	Total lack of or nonaffective, shallow, impersonal involvement in animate world	Emotionally distant, aloof, and/or impersonal (highly ambivalent)	Angry and impatient covered by mask of impersonal professionalism	"Woo" caregiver into a relationship, point out pleasurable aspects of baby
Somatopsychological differentiation (3-10 mo) (Purposeful communication)	Behavior and affects random and/or chaotic or narrow, rigid, and stereotyped	Ignores or misreads (e.g., projects) infant's communications (e.g., is overly intrusive, preoccupied, or depressed)	Vacillates between overcontrol and avoidance (of intrusive caregiver) or overprotectiveness (of depressed caregiver)	Combine empathy and limit setting with sensitivity to reading subtle emotional signals; help caregiver read infant's signals
Behavioral organization, initiative, and internatization (9-24 mo) (A complex sense of self)	Fragmented, stereotyped and polarized behavior and emotions (e.g., withdrawn, comliant, hyper-aggressive, or disorganized behavior)	Overly intrusive, controlling; fragmented, fearful (especially of toddler's autonomy); abruptly and prematurely "separates"	Premature separation from or rejection of family rationalized by notion: "they are okay now"	Support family self-sufficiency, but with admiration and greater rather than less involvement
Representational capacity, differentiation and consolidation (1½-4 years) (Creating ideas and emotional thinking)	No representational (symbolic) elaboration; behavior and affect concrete, shallow, and polarized; sense of self and "other" fragmented, undifferentiated or narrow and rigid; reality testing, impulse regulation, mood stabilization compromised or vulnerable (e.g., borderline psychotic and severe character problems)	Fears or denies phase-appropriate needs; engages child only in concrete (nonsymbolic) modes generally or in certain realms (e.g., around pleasure) and/or misreads or responds noncontingently or unrealistically to emerging communications (i.e., undermines reality orientation); overly permissive or punitive	Infantilizing and concrete with family, providing instructions, but no explanations or real sense of partnership	Create atmosphere for working partnership; learn from caregivers and help them conceptualize their own approaches

whose members in turn communicate their stress to the service team. In this context, it is not unusual for the service team—with the best intentions—to themselves fall into a pattern of being covertly rejecting, or critical and punitive, or overcontrolling or infantilizing.

To remain helpful to a stressed family (and the infant involved), a service team must avoid reacting as one more link in the maladaptive chain. The following steps can help:

- Containing the emotional reaction of team members by extra empathy, support and structure, including limits (This will often require opportunities for each team member to have one-on-one supervision or peer consultation);
- Working to understand the emotional patterns of infant and family;
- Using introspection to understand team members' own expectable emotional reactions to infant and family;
- Using (rather than acting on) immediate feelings to understand how the family feels (e.g., "if the family makes us feel disorganized and aversive or overcontrolling, perhaps that is how they are feeling; perhaps we are feeling like them, or the opposite of them—let's see how we can use our introspective understanding to be of assistance to them")
- Planning a corrective team and family emotional strategy to be integrated with the specific treatment plan.

Team members can help each other. Sometimes the team member closest to the family is the one who most reacts to or overidentifies with family distress. Others can take a step back and help the involved team member see the larger pattern. Table 1 outlines some common clinically observed infant, caregiver and service provider team patterns.

Conclusion

Recent understanding of infant and family emotional functioning now makes it possible to pinpoint emotional milestones much like the neuromotor milestones. This "road map" may prove helpful in facilitating adaptive emotional growth in infants whose sensory, motor, intellectual or physical differences set into motion unique family challenges.

We must always remember that "there are many roads to Rome." Almost all infants and young children can learn—in different ways—to relate to others, to interact intentionally, to organize a sense of self, to learn to use ideas to guide behavior and label feelings to test reality, to modulate impulses and mood, to experience positive self-esteem, and to concentrate. Our challenge is to provide infants and young children with learning opportunities that are sensitive to their individual differences and to their unique potentials for physical, cognitive, social, and emotional development.

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For your information

The 15-member **National Commission to Prevent Infant Mortality** has issued its report, *Death Before Life: The Tragedy of Infant Mortality.* The two major recommendations of the report are: 1) provide *universal access* to early maternity and pediatric care for all mothers and infants; and 2) make the health and well-being of mothers and infants a national priority, with appropriate attention and resources. The report outlines a range of steps that can be taken by government, communities and the private sector to advance these broad courses of action. A 115-page appendix to the report includes a history of federal initiatives to reduce infant mortality and issue briefs on postneonatal mortality, maternal and child health provider issues, minority populations, financing, and the Title V Maternal and Child Health Services Block grant, among other topics. The life of the Commission has been extended for at least one year to work toward implementation of its recommendations. Individuals may request up to 10 copies of *Death Before Life* and the *Appendix* free of charge from the National Commission to Prevent Infant Mortality, Switzer Building, Room 2006, 330 C Street, S.W., Washington, D.C. 20201, tel: (202) 472-1364.

A majority of Americans think of child care as an urgent need in the country today and express strong support for governmental initiatives to assure families of the availability of affordable, quality child care services, according to a national telephone survey conducted in early June, 1988 under the joint sponsorship of the **American Federation of State, County and Municipal Employees (AFSCME)** and the **Children's Defense Fund.**

Seventy-four percent of all voters believe it is "difficult" for parents to obtain child care that is both affordable and of good quality. Seventy-five percent of all voters feel that the federal government should establish minimal standards of health and safety for child care facilities, rather than leave such standards to the States. Eighty-three percent of working mothers and 63 percent of all voters, according to the survey, believe the federal government should develop policies to help make child care services more available and affordable for working families. After hearing a description of the Act for Better Child Care, 60 percent of voters surveyed favored ABC, with support coming from every region of the country, from all age and income groups, and from voters who are not raising young children as well as from working parents. Even when the $2.5 billion cost of ABC and the federal deficit were emphasized by questioners, a majority of voters continued to assert their support for investing in child care.

Ann Turnbull, H. Rutherford Turnbull, III and Jean Ann Summers will co-direct the **Beach Center on Families and Disability at the University of Kansas,** the first federally funded national rehabilitation research and training center on families and disability. With support from the National Institute of Disability and Rehabilitation Research in the U.S. Department of Education, the Beach Center will engage in research, training and dissemination of information relevant to families who have members with developmental disabilities, or serious emotional disturbances, members who depend on technology for life support, or members who are disabled or elderly. For further information, including inquiries about work concerning a specific disability population or issue, contact Gary Brunk, The Beach Center on Families and Disability, The University of Kansas, Lawrence, KS 66045, tel: (913) 864-4950.

Perspectives on Practice

Dramatic Responses in a Safe Space: Helping Parents to Reach Difficult Babies

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Sensory-affective interaction is a systematic intervention method which focuses on strengthening parent-infant communication in order to increase infants' motivation and competence. The technique is called sensory-affective because it concentrates on helping the infant generate increasingly well-organized, sensory-motor and affective behavior. Positive emotional expression by the infants, because it supports their motivation for exploration and desire for social involvement, is a major goal of the intervention. Emotional expression has a central role in parents' responses as well. Parents are encouraged to react to infants' behavior with sharply focused, clearly expressed feelings, to communicate to infants that their behavior has a strong effect on others.

The sensory-affective interaction approach reflects a view, based on the work of Harlow (1958); Mason and Berkson (1975); Anthony (1983); Stott, Musick, Clark & Cohler (1983); Ainsworth (1967); and Mahler, Pine & Bergman (1975), among others, that infants' motivation for mastery and their sense of themselves as competent seem to have two sources: 1) their relationship with their parents and 2) their experience of using their bodies effectively. In an optimal parent-infant relationship, children's needs are readable and predictable, and children respond promptly to the parent's actions and reactions. As such children learn from their successes in affecting their environment, their behavior becomes more specific and focused and they become able to deal with increasingly complex situations. These children simplify the parenting task. Their mothers feel more confident about their parenting skills, and these skills, in turn, improve (Goldberg, 1977, 1979). Similarly, a particular style of parenting—characterized by a sensitive, contingent, child-centered responsiveness—increases children's sense of effectiveness and control over the environment, thus encouraging further exploration and interaction.

Whether it begins with the child or the parent, when one or both partners experience difficulties in interaction, the infant's behavior can become increasingly disorganized and the relationship can be threatened. A mutually satisfying interaction pattern becomes less likely when the infant's behavior is unclear, unpredictable, or nonresponsive, as well as when the parent's behavior toward the child is noncontingent, highly controlling, or unskilled.

It is clear that both parents and infants influence the course of development. The infant's inherent problems or strengths in being able to organize his or her own behavior must be taken into account. **Therefore, a basic component of an interaction-based intervention should be the generation of interchanges through which children experience joy, success, and mastery as an outcome by experiencing control of their own bodies and the environment.**

FLORENCE SHARP

Besides trying to optimize parent-infant attachment through effective communication, sensory-affective interaction (SAI) shares basic components of several interventions used with older children having various problems in development: a concern with fun, effectance, self-other differentiation, and sensory-motor organization. When involved weekly in active, highly enjoyable activities, environmentally deprived children have demonstrated significant academic gains (Brody, 1978; Brody, Fenderson, & Stephenson, 1976). Focusing on helping the child feel more in control of the environment through communication has been of great help to both deaf/blind (Van Dijk, 1965) and other severely/profoundly handicapped children (Sternberg, Battle, and Hill, 1978). Using tactile stimulation has helped autistic children become more aware of themselves and others (Des Lauriers and Carlson, 1974). Helping the child develop better coordination through structured, motion-based activities has been found to assist children in overcoming learning disabilities (Ayres, 1972).

The role of the therapist is that of a facilitator of communication between parent and child. The therapist can function in a variety of ways. Generally speaking, the fewer problems the parent and child have in interaction, the more supportive and reinforcing the therapist can be. The greater the difficulty, the more the therapist needs to make suggestions, to encourage play among the parent, child, and therapist, or to try out new activities. In our experience one principle kept emerging: **When we could identify a parental concern and start with it as the first focus for sensory-affective interaction, parents became willing participants in sensory-affective interaction.**

In SAI the primary role for the parent is to respond contingently and expand upon the child's activity, thus increasing the child's motivation and contributing to the child's feeling effective. In the course of treatment, parents are taught how to read the child's behavior, respond with positive affect, and behave in an exaggerated manner to make their cues clearer to the child. We look for the child to first notice, next smile, and then to present organized gestures asking for an experience to happen again. Thus the child has an opportunity to feel in control of his or her own body and the environment and to feel motivated and competent.

The importance of children's awareness of their own body boundaries should be emphasized. They need to feel secure and know exactly where they are located in space. If not, their discomfort or level of tension interferes with effective communication. Treatment should be framed in a space reflecting the child's developmental level. It is best to begin with the child prone or supine. When the infant is able to look, smile, laugh, and begin to use gestures in a reciprocal turn-taking way, the behavior is well organized (this level of social achievement is characteristic of normal 3 to 4-month-olds). The child is then ready for more interaction in a sitting position, on the lap or face to face. Similar parameters are used for assessing the quality of infants' communication as the interaction moves from sitting to crawling, to walking, to running.

What is most important about the children's behavior is not whether they can perform a motor act but that they can do it and communicate effectively at the same time. Many children, at times, cannot. They need then to be returned to a developmentally earlier physical plane, closer to the ground with less large motor activity.

Developmentally focused activities in SAI are structured to offer sharply organized kinesthetic, tactile, visual, and auditory stimulation. The materials used (e.g., towel, baby lotion, mirror, masking tape, beach ball, bubbles) encourage interaction. More traditional toys may come between child and adult. The more severe the impairment, the more the parents must direct activities and the more they must sharpen their own behavior while still remembering to read and respond to their child's cues. As the child develops socially, and sensory-motor skills become more organized, the activities become more sophisticated. Dolls and other toys can be introduced as the child approaches the one-year level of social development. Yet the activities retain the emphasis on the parent-infant interaction. Imitating or mirroring, turn-taking, dramatic response to the child's behavior, and play themes of daily activities all become important facilitators of communication. As the children grow older, new developmental issues come into play and need to be addressed. For example, a child with an attachment disorder may need help learning to interact with peers at age 2, and help adjusting to school at age 4.

Change is difficult; the child may object to our activities. We have found when the child resists, compromise is effective. While we may have identified the skills the child needs to master if development is to be orderly, the child may not agree with our choices or timing on how to help. As we respect the parent, we need to respect the child, but at the same time, the child cannot afford for us to take no for an answer. Persistent invitation best describes the approach to a resistant child. The child tells us how much is too much and when we are using the right activities to pursue our goal. If the child objects to our activity, our answer is "Oh, you don't like ______!" (what the parent is doing), but never "Oh, you don't like me!" We encourage the parent to try "Well, then how about ______?" (another activity or even a rest), but not to give up. If the child responds in a well-organized way, we are on the right track. If the child's behavior becomes disorganized, we change our behavior, searching for something which helps the child have fun and feel better organized. In this way children learn they do have control over specific activities, and we can pursue our goal of increased involvement. An example:

> In a group of teenage parents and 8 to 12 month-old infants, one 8-month-old was very dependent and clingy. The child and mother had moved five times in the child's lifetime. The mother was exasperated with him and teased him when he cried at being put down on the floor. Of course, her teasing made him more upset and demanding. She said she would like help with teaching him to become less dependent on her. In the group he was afraid of strangers and refused to play with other infants or move away from his mother. If anyone tried to interact with him, he became upset and clung to her all the more. We noted that his dependence meant that he cared about her. We asked her to comfort him right away when he asked. She saw him become much less fussy and, hence, less demanding. We explained that if he felt understood and secure, he would be ready to try being on the floor.
>
> The leader and mother worked together to help him separate by encouraging him to have fun, first on her lap, then on the floor leaning on her, and then very gradually farther and farther away from her. First, through feeling understood and accepted, and then through fun, he gained confidence in being on his own. In three sessions

he moved through space comfortably, enjoyed interacting with other children and adults, and he could tolerate his mother leaving the room.

Below we present a case study illustrative of how sensory-affective interaction may be used in intervention. (A videotape of the sessions described is available from the author.)

Case Study, Aida

Aida's mother, Stacy, age 27, was a heroin addict with a long history of psychiatric problems, including bulimia, frequent psychosomatic complaints, and antisocial behavior.

When she discovered that she was pregnant, Stacy decided that she wanted to get off narcotics. Towards the end of the first trimester, she entered a residential treatment center, and initiated a plan with a private social-service agency which stated that after birth her child-to-be would be placed in a temporary foster home while she first quit heroin, then found a home and applied for public aid. When her situation became more stable, Stacy was to take custody of her child. Since the methadone Stacy received as part of her therapy produced severe side effects, she was placed on a methadone placebo. Aida was, therefore, not addicted to opiates at birth, but she had to undergo narcotics withdrawal in utero, a phenomenon known to be stressful to the fetus (Wallach, Jerez, & Blinick, 1975).

Stacy gave birth to Aida on June 30, 1980 after a 14 hour labor. Aida was delivered by low forceps. She weighed 2000 grams (4lb. 6½oz.); her gestational age was 36 weeks, and her Apgar scores were 8 and 9. At three weeks of age, Aida was placed in a temporary foster home with Mrs. Fedders while her mother continued in residential treatment. When Aida was eight weeks old, Stacy apparently began to feel that her rehabilitation was going badly; she left residential treatment and "disappeared." The foster placement was recategorized as permanent, and Aida continues to reside with Mrs. Fedders, who adopted her when she was four years old.

Stacy had been enrolled in our research study of the development of infants born to mothers maintained on methadone (Marcus, Hans, Patterson, & Morris, 1984). The social service agency responsible for Aida requested that we continue to follow her even though her biological mother was no longer a participant in our project, and we agreed. A summary of our developmental findings on Aida leading up to our intervention follows.

Aida's Brazelton Neonatal Assessment Exams (Brazelton, 1973) were generally unremarkable. She exhibited odd physical posturing at both her one-day and one-month exams (ages corrected for gestational age). Although difficult to reach at one day, she was responsive at one month, attending well to people and objects. She was generally calm and alert. At four months of age she was tested on the Bayley Scales of Infant Development. Her scores were 94 on the Mental Development Index (MDI) and 103 on the Psychomotor Development Index (PDI), both scores falling within the normal range. She was again calm and alert, but she was not very interested in people or objects. We were not yet concerned about her development. We saw her again at 8 months of age. She had a cold and cough. She was very fussy, clingy, and afraid of strangers. She showed minimal interest in the Bayley exam. Her MDI score was 84, and her PDI 64, well below average, but we discounted the results because of her illness.

JOHN DAVID ARMS

At one year of age her behavior was severely problematic. She insisted on clinging to Mrs. Fedders. Aida showed minimal responsiveness to the examiner, who spent a long time trying to "warm Aida up" and coax her out of her fearfulness. She began to rock and suck her fingers when a Bayley task was presented. Aida neither explored the test materials nor responded to the examiner, although she watched everything intently. When the examiner tried to interact playfully, Aida became upset and started to bang her head. Mrs. Fedders reported that she only wanted to be held at home; Aida did not like to interact. Aida's Bayley performance was below the scale norms of 50. We shared our concern and asked Mrs. Fedders to return with Aida for further assessment.

In our observations of parent-infant interaction we ask parents to interest their children in a doll or to play a game with them. These were activities which virtually all one year olds in our study enjoyed. However, Aida did not. She looked at the doll, but did not reach out to touch it. She pulled away when her foster mother offered her the chance to hold it. She seemed paralyzed, not being able to push the doll off her lap with her hands. Instead, she tried unsuccessfully to get out from under the doll. When Mrs. Fedders tried to engage Aida in a game of pat-a-cake. she again refused. She leaned forward to be held. She whined when Mrs. Fedders tried to get her to play again. Throughout these play times, she had a pained expression on her face. When her foster mother was asked to leave the room for two minutes. Aida reacted with panic. She immediately screamed and began to hit her head on the mat; she did not try to follow. She refused our offer of comfort. Although most other one year olds become upset at brief separations, they usually try to follow their mothers out of the room and do not panic in the presence of a non-threatening adult. When Mrs. Fedders returned (90 seconds earlier than originally planned), Aida crawled over to her and gestured with her arms that she wanted to be picked up. This was the only time she voluntarily moved through space. However, at no time during the one-hour observation did Aida smile or even relax.

Mrs. Fedders afterwards said, "That's what she's like at home." She wants to be held all the time. She doesn't want to interact. Mrs. Fedders, who has cared for autistic children, said that some of Aida's behavior reminded her of them. In particular, she noted that Aida rocks when something is bothering her and bangs her head when angry or going to sleep at night. At this time we decided we should intervene with Aida, using sensory-affective interaction as the primary tool. We explained to Mrs. Fedders that, although Aida was delayed in her development, our greatest concerns were her constant fear of others, even of people she knows, and her refusal to explore her environment. We said that we would concentrate on helping Aida develop self-confidence through interaction with her foster mother. Mrs. Fedders concurred that Aida needed extra help. She agreed to attend weekly sessions with her. Over the subsequent four months, we usually were able to see Aida on a weekly basis. A summary of some of the highlights follows.

August 11, 1981—Age 12½ months (gestationally adjusted age): In our first session I tried to find ways to get Aida to respond while explaining my actions to Mrs. Fedders. Aida spent the whole session on her mother's lap in a chair with her head tilted away from me and into her mother's breast. She whined in general irritation at all my attempts to get her to respond. Finally after about a half-hour, she repeated a movement that I had done to her body. I put her leg through three kicking motions while I said "Kick, kick, kick." She kicked her leg several times in a row and I said "Kick" each time she moved. We repeated this sequence three or four times. I explained to Mrs. Fedders that I was using firm physical contact to help Aida know where she was in space; the less lost she felt the less fearful she would be. I was trying to get Aida to use her body through enjoyable physical contact so that she could feel more confident in space and want to move around more. At this point Mrs. Fedders said timidly, "She was so tiny when I got her, and I think I always handled her real delicate." It appeared that they had developed a powerfully symbiotic and dependent relationship. However, it was born not from parental psychopathology, but from the circumstances under which Aida came to live with Mrs. Fedders.

August 25, 1981—Age 13 months: Mrs. Fedders was strikingly different in this session; she was much less cautious and spoke to Aida in a firmer manner. Although she is a large woman and it was obviously difficult for her to move, she willingly accepted my suggestion that she and Aida sit on the tumbling mat. She said, "Can I get down there with you, Aida?" Mrs. Fedders placed Aida across from her and Aida began to whine. She said, "Oh, come on, come on, I'm down here with you. Are you all right?" Aida quickly stopped whining, in contrast to her behavior in the previous session. Mrs. Fedders began to sing, "Tickle, tickle toes," as she lightly touched Aida's feet. Aida reached over and picked up an open baby-lotion bottle and tried to put it in her mouth. Her mother promptly and firmly told her "No!" and took it from Aida. At this point Aida said angrily, "Eh! Eh!" and slapped at her; Aida wanted the bottle back. Mrs. Fedders closed it and gave it back to her. Aida's complaining sounds, of which there were many, and gestures were much better organized and focused than anything she said or did the previous session. It was a relief to hear a sound other than a whine.

On her own Mrs. Fedders took a towel, put it over Aida's head and began to play peek-a-boo. Aida was not impressed. At first Mrs. Fedders took the towel off. I discussed with her waiting for Aida to respond before she did it. Then she waited for Aida to do it herself, and Aida did. The second time she had to do it herself she pivoted in space to get the towel off more easily. This was the first time I had seen Aida move through space when she was not upset. This activity seemed to be a little too much for Aida and she crawled to her foster mother to be picked up. I suggested she give Aida a brief bear hug instead and return her to a standing position where she could lean on Mrs. Fedders for support but not for clinging. At first Aida complained "Eh, Eh." I suggested the activity be repeated. By the third time Aida was stretching her arms out to request another hug, by the fourth time she smiled (the first smile I had seen), and by the fifth she actually looked proud of herself. Clearly both Aida and her foster mother were developing confidence in themselves as they were having fun together. They were beginning to enjoy moving their bodies purposively.

September 3, 1981—13½ months: Mrs. Fedders had been more active with Aida at home. At bed time she had been giving her body massages with baby lotion. She had been handling her more firmly rather than with kid gloves when she asked to be picked up. She also had been doing more active physical play with Aida. The session began with Mrs. Fedders giving Aida a flip (somersault). Aida loved it and smiled broadly. Shocked, I said, "What happened to the little fraidy cat?" Aida left Mrs. Fedders and walked over to me smiling, with the hiccups, and saying "Chee Chee." She had begun to walk! This was also the first time she had approached me and made positive vocalizations. I pushed a beach ball into her stomach as she made loud, playful sounds. She enjoyed having her voice resonate with vibrato. She then walked back to Mrs. Fedders, who tossed her up in the air. Aida actually laughed. She did another flip, but this time Mrs. Fedders lost hold of one arm and Aida pivoted sideways awkwardly. She smiled, but seemed to need a break. Aida walked around the coffee table, grabbed a Kleenex box, held it up for us to see, and began to walk while holding it. As she moved she said something which sounded like "I got it!" directly to her foster mother. She walked over and handed the box to her. I pointed out to Mrs. Fedders that Aida's walking, vocalizations, smiling and laughing, and reaching out to make playful contact all had come on just when Mrs. Fedders had begun to relate to her with more gusto. I told her I felt it was more than coincidence or simply a case of maturation. Mrs. Fedders, feeling more confident in interacting with Aida, helped the child become motivated to be involved with the world instead of being afraid of everything.

October 7, 1987—14½ months: Aida had continued to make good progress in both her social and physical competence. She was usually smiling throughout our sessions; she was constantly approaching people to engage them in play with lotion, masking tape, a ball, or whatever. But all was not perfect in paradise. Although Aida was looking more and more like a normal one-year-old, she was still prone to extreme reactions when upset. At the beginning of the session Mrs. Fedders said, "We went visiting Sunday after we left church, and she was miserable. It took such an effect on her." I said, "When you went to see those strangers?" Mrs. Fedders replied with frustration, "They weren't strangers! She's seen them at my house and she's seen them at church. Oh but being over there at their house! She had nightmares about it. I had to bring her in the bed with me." Aida's reaction seemed similar to her upset at separation during the diagnostic session. We decided that we should work on separation to help her deal with distress and learn that she need not become so overwhelmed.

While Aida and I were playing happily together, Mrs. Fedders got up and told her "I'll be right back." Immediately, Aida began to scream and cry full blast. I, her good friend, could not comfort her. I picked her up and we dashed after Mrs. Fedders. Mrs. Fedders said again with frustration, "That's the way she acts. If I just get up, if I just so much as raise my body from the seat, she has a tantrum."

I was disappointed as I realized that the course of treatment would not be as smooth as it had first appeared. Although her social relatedness, positive emotional expression, and involvement with the environment were beginning to be on track, she still was overwhelmed far too easily. A variety of everyday events which only inched away from the familiar and predictable would cause her to become upset. The degree of panic was always full blown, essentially independent of the event itself. Aida was to require a great deal of help both in learning to accept more varied activities and in modulating the intensity of her negative emotional reactions.

November 18, 1981—16 months: Since we had decided to help Aida manage separation anxiety, we had met four times. At each session Aida gradually was able to manage the separation better. We alternated having Mrs. Fedders leave Aida with me in the playroom for two minutes and having Aida and me visit other staff members, leaving Mrs. Fedders in the playroom. The previous week she had been minimally unhappy and allowed me to comfort her, and she seemed to enjoy our treks to other offices. At this session she continued playing with me undisturbed when Mrs. Fedders left. Mrs. Fedders and I next left together for two minutes. She played a minute and then walked to the door where she waited for us calmly. She was very happy when we returned, greeting us with a big smile and wanting to be picked up.

We thought at first that she was unaffected. However, when Mrs. Fedders tried to put a smiling Aida down, she began to have a tantrum. Mrs. Fedders quickly reversed Aida's mood by twice tossing her in the air. Aida, having regained her composure, began to try to master stepping up on the tumbling mat and down again. She worked on this for several minutes. We were quite pleased that she began to explore the environment shortly after becoming upset rather than insisting on being held as she had done in the past. This prompt return to exploration after deriving comfort from physical contact with the mother is indicative of a secure attachment, which has been found to form a good foundation for the child's subsequent social development.

The session on November 19, 1981 concluded our scheduled weekly contacts. Mrs. Fedders' main concerns could no longer be dealt with in our office. She noted that Aida could not get along with other children. Also Aida would not go out with any other family members unless Mrs. Fedders came along. We agreed to meet monthly and try to plan steps for what she could work on with Aida at home. But, in reality, our connection began to weaken, and Aida had not made adequate progress in these areas.

May 2, 1982—age 21½ months: We made a home visit. Once again I was disappointed. Aida behaved much as she had done at the diagnostic visit nine months earlier. She acted like she was afraid of me. She insisted on being held, sucking her fingers, and twirling her hair. When her foster mother left her with me in the dining room to go into the living room to turn on the record player, she again began to scream and throw a tantrum. This time Mrs. Fedders' attempt to distract her by rough-housing were unsuccessful. Aida insisted on clinging to Mrs. Fedders throughout our visit.

Their home adjoins a parking lot. Mrs. Fedders said, "That's what she's like. She has a fit whenever anyone pulls up and parks their car." She went on to say that Aida always got upset when Mrs. Fedders tried to do something with any of the other children. I realized that without our regular contacts old patterns had begun to re-emerge. Mrs. Fedders and I had to start working together more closely, as we had before.

We backtracked and re-emphasized the playful interaction and solid physical contact. I suggested that rather than interacting only with Aida or only with the other children that Mrs. Fedders try to lead activities involving all of them together. This way Aida would not be calling all the shots and it would be harder for her to gather momentum from practicing her maladaptive dependency pattern. Relatively quickly Aida began to improve. Bi-monthly contacts proved sufficient to maintain improvement.

December 5, 1982—28½ months: I made another home visit. Aida was running around and laughing most of the time. She was the leader in the group of four preschoolers. She initiated playing ring-around-the-rosy with them and had the foresight to position herself where she could cushion her fall. She invented a game of running into the kitchen and coming back to the dining room and diving on the day bed. The other children were quick to follow and they all did it five times. They were having a wonderful time together. Aida was now talking in three-to four-word phrases. We had a long conversation as to whether or not her soup was too hot at lunch time. It was once again an amazing transition.

The following summer a trauma occurred. Aida had gone to the zoo with Mrs. Fedders' sister and her children. In the large mammal house she had become terribly frightened at seeing the hippopotamus and rhinocerus. With only a moat between her and the animals, she apparently felt unprotected. The whole group had to leave. She would not quiet down until she got home with Mrs. Fedders. That night she had nightmares and wet the bed. She had to sleep with Mrs. Fedders for a week.

Mrs. Fedders and I had begun to see a pattern in Aida's reactions to upsetting experiences. Aida, unlike most other children, was always bothered by change. She had now progressed to the point that usually, with sufficient support and encouragement, she could overcome many things which bothered her. Without that support she would revert to her maladaptive dependency pattern. Even with support and encouragement, some situations were too much for her. This understanding was of great help in planning to introduce her to new situations.

In September, 1983, at age 3 years 2 months, Aida entered a Montessori preschool. We felt that the Montessori school was a good choice because it was low key and highly structured. We decided that her foster mother should stay with her at first until she was settled. Surprisingly, this only took three days. The school provided bus service. It took Aida much longer to adjust to the bus ride, and Mrs. Fedders had to ride to school and pick her up for more than a month.

There have been many other situations in which Aida's need to feel in control interferes with her functioning. One can not discipline her if she has already become excited, angry or upset. At these times one can only try to help her calm down and then develop some rules for the next time such a situation might occur. Once prepared, she is able to respond to adult direction, but she becomes enraged and disorganized if confronted or treated in an authoritarian manner.

Interestingly, during our twice-yearly psychological evaluations, she has resisted the tasks demanding verbal performance. In these activities she scores one to two years below age level. On tasks allowing her to interact with materials at her own pace, she performs at age level.

For these reasons her mother decided to have Aida repeat kindergarten in the local public school. Initially, she had difficulty adjusting, being described as "hyperactive" by her teacher. Once her teacher learned how to interact with Aida, she has responded beautifully—her last report card was straight A's, and she won the primary level Dr. M.L. King oratory contest.

Aida has progressed very well, but she is not yet whole. Brazelton (1984) has spoken of touchstones, transition points in development during which families are likely to experience additional stress and would benefit from extra support. I believe these points will be more difficult for Aida than for other children. Over and over she has shown that she needs special on-going support to function normally. Her pattern of a disorganized physical sense of self, excessive upset, and dependency, while weakening, still lurks in the background. She still looks the same when she becomes tired or upset, sucking her fingers, twirling her hair, and banging her head against the wall in the middle of the night.

On the positive side, she has developed the self-confidence to charge into the world around her. As her mother recently told me (January 14, 1987), she challenges things all the time. She wants to know the reason for everything—just like any other 6½-year-old.

Conclusion

To improve parent-child interaction is to improve the course of development. We have found sensory-affective interaction an important treatment tool for generating developmentally appropriate infant-parent communication. SAI strives to create mutual delight between infant and parent while focusing directly on improving the parent-infant relationship. The interaction intervention is appropriate for problems with either environmental or organismic etiologies. The strength of SAI lies in its focus on developing competence. It is human nature to pursue what feels good, and infants' and parents' experience of mastery together encourages development in a positive direction.

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experience pain. Many anesthesiologists and neonatologists, in their concern for the welfare of the infant, focused on the potentially deleterious side effects of analgesics and anesthetics on the newborn's physiological organization. The judgment was frequently, though implicitly, made that it would be better for the infant to suffer short-term pain than to endure potentially life-threatening side effects of medication.

As a result of the belief in neonatal insensitivity, pain in infants has been undertreated. Review of hospital records of pediatric patients indicates that physicians order less pain medication for children than adults, and nurses administer fewer analgesics (Beyer, DeGood, Ashley, & Russell, 1983). Comparison of pediatric and adult patients undergoing the same surgical procedure has revealed that children receive fewer post-operative pain medications than adults, and sometimes none at all (Eland & Anderson, 1977). Another consequence of inadequate understanding of pediatric pain has been the neglect of painful side effects of such procedures as heelsticks, circumcisions, intravenous line placement, spinal taps and tracheal suctioning. However, if prior beliefs about infant insensitivity to pain are wrong, and if the adverse effects of pain-eliciting procedures can be avoided, health providers must reevaluate their current practices. It is the thesis of this article that infants indeed experience pain in adult-like fashion, and that behavioral and environmental interventions can markedly influence the quality of experience an infant has when undergoing painful but necessary medical and nursing interventions.

The evidence that infants do experience pain

Recently, studies of infant behavioral and physiological responses to painful stimuli have sharply contradicted both the early findings of McGraw, and the idea that infants do not experience pain. Pain, like other basic emotional responses, can be measured by facial and vocal expressions, as well as by instrumental reactions. Painful facial expressions, for instance, consist of lowering and bringing together of the eyebrows, raising of the cheek muscles, and tight contraction of the eyelids. Newborns consistently show this pain facial expression when they are subjected to inoculations, heel lances, and other medical interventions. Their cries, with a sudden loud onset, an initial long cry and an extended period of breath holding in expiration after the long cry, are, like facial expressions,

National Center Notes

by Eleanor S. Szanton

This edition of National Center Notes is a reprint of testimony which we were asked to give before the Federal Interagency Coordinating Committee, a group of representatives from six federal agencies that are responsible for facilitating the implementation of Public Law 99-457, the Education of the Handicapped Act Amendments of 1986. P.L. 99-457 mandates services for handicapped children from age three and provides incentives to states to prepare to serve children from birth through two years who have actual or potential developmental problems. Since Part H, the portion of the law which addresses children birth through two, requires strong interagency coordination in developing comprehensive services, and since all fifty states have chosen to participate in Part H, *there is a new and historic opportunity for policymakers to take responsibility for the healthy development of our nation's youngest children.*

The testimony which follows was given to the Federal Interagency Coordinating Committee on June 13, 1988 at the closing session of a meeting of representatives of all fifty state governments, convened to provide leadership in planning for the implementation of PL 99-457.

Madame Chairman, distinguished members of the Federal Interagency Coordinating Committee, representatives of the many state agencies and coordinating committees concerned with implementation of P.L. 99-457, and others who share our interest in this important new law:

It is an honor to speak to you at this historic time. Never before have our fifty states been so uniformly committed to developing comprehensive, coordinated programs to improve the lives of infants and young children and their families. Nor have they sought to utilize so systematically the strengths and resources of *families* to plan and develop such programs.

I am Executive Director of the National Center for Clinical Infant Programs, an independent, non-profit organization founded by leaders from a number of disciplines in the field of infant development. Our scope of work includes all infants, toddlers and their families—those facing the everyday stresses of childrearing in contemporary America and those confronting the challenges of disability, illness, social isolation or poverty.

It is from this broad perspective that I speak to you. And it is to this broad perspective that I wish to urge you to look. The research and clinical work of the last twenty years have made abundantly clear the fact that many children and their families have multiple problems or multiple needs, often feeding upon each other. Yet our funding streams are not set up to give coordinated attention to these needs, utilizing the child and family's strengths and community resources. Let's all commit ourselves to changing that, in deed as well as word.

At the federal level, there is an opportunity to suggest how funds from many different sources can be utilized and coordinated by states to provide comprehensive systems. These include the Education of the Handicapped Act; Title V of the Social Security Act (the Maternal and Child Health Block grant); SSI; Title XIX (Medicaid, including EPSDT); Title XX (the Social Services Block grant); Head Start; Title IVA (AFDC), which will be the enabling legislation for welfare reform; Title IVB (funding foster care, adoption, and child abuse prevention); the developmental disabilities legislation; and funds from the Child and Adolescent Service Systems program (part of the Mental Health block grant). We strongly congratulate those agencies of the federal government present here today for your commitment to a joint effort to help our nation's youngest children achieve their full potential. We urge you to encourage other relevant agencies with jurisdictions over these various funding streams to join you as well. We also urge that you systematically incorporate a parent perspective into your group, as states are now doing.

In 1986, our organization published a position paper entitled *Infants Can't Wait*, which may be useful in your deliberations. The document describes why attention to the early years is important and suggests a two-pronged approach to the development of services for infants and toddlers and their families. One is the establishment of a basic level of integrated services for *all* infants and toddlers and their families. This includes preventive health care, a level of economic well-being necessary for basic health and development, family social support services, and daily care for all infants and toddlers which recognizes their need for ongoing daily experiences facilitating their emotional and cognitive development. The other "prong" is the expansion of comprehensive, integrated services for infants and toddlers with special health and developmental problems or disabling conditions and their families.

As a companion to this position paper, we published a data book on the status of infants and toddlers, *Infants Can't Wait: The Numbers*. This second document outlines one area after another in which the lives of very young children in this country are compromised, based on a reading of official statistics. It is important to remember that **it is not enough to have a strong early intervention program stressing least restrictive environments if a toddler is then going to be mainstreamed into a day care program where there is an average staff turnover of 40% per year, or if the child has not received a polio vaccine before entering that day care center or if the lead level in her blood is dangerously high. It may do harm rather than good to have a welfare reform program if the infant whose mother is benefitting from it is in such poor daily care that he may require special education when he reaches school age.**

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also characteristic of pain experience (Wolff, 1969). Perhaps most surprising of all is the recent observation by Franck (1986) that babies actively swipe at the source of the pain with the unaffected leg, even in the newborn period. Babies thus show the expressive and instrumental manifestations of the experience of pain.

Perhaps more significantly, babies show clear evidence of physiological stress to pain. Heart rate, which is a major indicator of the overall metabolic demands on the organism, increases up to 50 beats per minute after the heelstick (Owens & Todt, 1984). Such changes constitute a 40% increase from an infant's typical resting level. Along with increases in heart rate, there are other physiological indicators that painful stimulation causes a major stress reaction in newborns and young infants (Anand & Hickey, 1987). For instance, one of the main components of physiological stress reaction is rise in cortisol levels. Such rises typically accompany hedonically negative experiences, and reflect the body's attempt to release blood sugar and combat inflammatory consequences of stress. Following circumcision, serum cortisol levels increase markedly (Gunnar, Malone, Vance, & Fisch, 1985) and transcutaneous oxygen saturation declines (Maxwell, Yaster, Wetzel, 1986). In addition, elevations in arterial blood pressure and intracranial pressure have also been reported during tracheal intubation of infants with compromised respiratory capacity (Kelly & Finer, 1984). In sum, the physiological state of the infant undergoing pain stimulation is one of coping with the trauma.

Painful experiences in the newborn have the potential of disrupting the emerging parent-infant adjustment. And although infant reactions to acute distress often appear short-lived, pain in infancy may have unsuspected long-term consequences.

In addition to the physiological and expressive reactions indicative of pain and stress, other important behavioral changes take place following painful encounters. These include irritability, jerky motor movements, withdrawal from social interaction, and decreased ability to self-soothe. Reduced periods of alertness also occur in infants who undergo circumcision unrelieved by anesthesia (Dixon, Snyder, Holve & Bromberger 1984). In the post circumcision-period, infants are less likely to sustain interactions with their parents or to cope with additional stresses such as delayed onset of feeding or additional pain insults. Consequently, painful experiences in the newborn and their accompanying behavioral manifestation have the potential of disrupting the emerging parent-infant adjustment in the neonatal period (Korner, 1974).

Perhaps one reason that infant pain signals have been ignored is an implicit assumption that painful experiences have no lasting effects on an infant's behavior. Infant reactions to acute distress often appear short-lived. Newborns, for instance, stop crying within 3-5 minutes after a heelstick. Moreover, infants seem to have a remarkable capacity to recover from stress. Following circumcision, the infant falls into a characteristic quiet sleep state for several hours, a state that many believe has a restorative function (Emde, Harmon, Metcalf, Koenig, & Wagonfeld, 1971).

However, contrary to expectations, pain in infancy may have unsuspected long-term consequences. Studies of neonatal animals have shown that painful or stressful reactions in early infancy can have major consequences in later life for emotional conditioning, problem solving, and even adrenal functioning (Levine, 1959). The recent studies on the reinstatement of memories by presentation of memory retrieval cues also caution against assuming that early memories are easily lost (Rovee-Collier, 1987). These studies have shown that infant memories can be retrieved well after retention seems to have been totally lost if the infant is placed in the same context as original learning took place. This work thus suggests that neonatal experiences may *sensitize* the infant to future stressful medical encounters. Consistent with this possibility is the report that infants who have undergone repeated heel lancing show *increased* sensitivity to pain over time (Fizgerald, Millard, & MacIntosh, 1988). Pain in infancy thus may well have unsuspected long-term behavioral and physiological consequences.

Behavioral interventions for soothing pain-elicited distress

If the experience of pain in infancy is both real and stressful, health care professionals must consider interventions to eliminate or reduce such stress. In this paper, we will review some behavioral interventions that appear promising in this regard. These recommendations for behavioral interventions will be drawn from the research on soothing interventions with infants.

A number of principles of infant soothing derived from studies which focus on prevention of infant distress have applicability for the relief of infant pain. At least six principles of soothing can be identified. These are as follows:

1. **The principle of constancy of stimulation:** In general, stimulation which is rhythmical, repetitive, or cyclic is likely to soothe an infant. The pacification of continuous stimulation is a general characteristic of sensory stimuli such as heat, light, and sound. Continuous rocking or sound is soothing, whereas intermittent stimulation tends to arouse the infant..

2. **The principle of additive effects of constant stimulation:** When infants are presented with two sources of unvarying stimulation, greater soothing is obtained than when there is only one source of monotony. For instance, Brackbill (1971) reported that constant light and sound produced significantly greater soothing effects than did constant light or sound alone. Constant light, sound, temperature and touch were even more effective than the combination of any two sources of stimulation.

3. **The principle of tactile stimulation.** Cutaneous stimulation, touching, has both arousing and soothing properties. Stimulation of large nerve fibers by pressure

Therefore, we urge you at the federal level to keep the big picture in mind. Specifically, we make five recommendations:

1) that when policies are suggested which comprise a full range of comprehensive services, all those federal agencies which have potential responsibility be represented. For example, the agencies which oversee education, health and developmental services for special needs children are clearly working diligently and with much success in coordinating their efforts. It is now time to work more closely with agencies which provide funds for the preventive health, social service and mental health activities of states as well.

2) that together you assure yourselves that the federal government is keeping and coordinating the collection of all data relevant to understanding of the status of infants and young children in this country. For example, is the surveillance of childhood immunization adequate at the federal level? the lead surveillance? the assessment of the number of children with handicapping conditions at various ages? the incidence of child abuse? state standards for infant day care? We think not.

3) that together you assure yourselves that an appropriate level and scope of technical assistance exists to support the broad perspective we are urging. For example, we strongly applaud the work of those federal agencies which have been able to provide technical assistance, opportunities for networking, and the promotion of best practices and models for states working with children with special needs. This same kind of support is lacking in other federal agencies such as those which concern themselves with day care and social services—areas which are part of a comprehensive picture.

4) that you must be sure your federal regulations and priorities facilitate a comprehensive approach for states. For example, regulations must help states delineate what aspects of services will be subject to the legal safeguards which are a hallmark of P.L. 94-142, while still encouraging state administrators to develop interagency strategies for reaching out to families of children who are "at risk."

5) and finally, that you recognize the need for adequate funding for this comprehensive attack. We have sadly seen within Title XX over the past eight years advocates for services for the elderly and child advocates essentially fighting each other over shrinking social service block grant funds. Now we see the same specter arising between advocates for poor or disadvantaged children and advocates for special needs children. It requires federal leadership to make investments in *all* our young children the highest priority.

We urge those at the state level to look at the big picture, as well. The Interagency Coordinating Councils for Part H will be a wonderful enabling mechanism in this regard. Furthermore, it is particularly heartening to see many states already putting their own funds into early prevention and intervention programs, adding to the federal sources. It is essential that these be well integrated with plans for P.L. 99-457. For example, how are you planning to utilize the new Medicaid legislation which will allow the working poor to receive basic preventive health care? Are you making plans to coordinate personnel preparation funds and activities with those which will become available if and when new child care legislation is enacted? How might you encourage coordinated use of child abuse prevention funds and EPSDT funds, along with P.L. 99-457 funds, to identify and serve all infants and toddlers at serious risk of stunted development in your state? How might you support and utilize the growth of family support and drop-in centers as well as day care centers to find children with actual or potential problems and work with their families to help them? How might P.L. 99-457 be most appropriately coordinated with existing and possibly expanded Head Start and similar programs?

Governor Clinton of Arkansas has said, "Our country cannot afford to waste a single life." We now know how to keep from wasting lives, and we know that to do so often requires a broad range of integrated services. Our job is to see that, with the help of families and the community at large, the services and their integration are achieved.

NOTE: *Infants Can't Wait* and *Infants Can't Wait: The Numbers* are available from NCCIP for $5/set, plus $1.50 postage and handling.

Call for Papers

The **Ambulatory Pediatrics Assocation** invites proposals for workshops and papers to be presented at its 1989 annual meeting, to be held May 1-5 in Washington, D.C. **Workshop proposals must be received by September 30, 1988 and paper abstracts by December 9.** For information, contact Marge Degnon, APA, 6728 Old McLean Village, McLean, VA 22101, tel: (703) 556-9222.

NAACOG seeks ½" VHS videotapes relevant to obstetric, gynecologic and neonatal nursing for showing at an 8-hour festival during its Seventh National Meeting in St. Louis, Missouri, April 2-6, 1989. Videos may focus on either nurse or patient education; they must be no longer than 40 minutes and must have been released in 1987 or later. **Entries must be submitted no later than November 1, 1988.** For information contact Denise Savage, NAACOG, 409 12th Street, S.W., Washington, D.C. 20024, tel: 1-800-533-8822.

The thirteenth annual conference of the **Michigan Assocaition for Infant Mental Health** will be held in Ann Arbor, MI, on April 17-18, 1989. Proposals for workshops to be presented should focus on the theme *"Expanding Our Approaches with Families: Attachment, Intervention, and Social Policy."* Abstracts may be sent to and additional questions addressed to Ann Saffer, 2340 Hickman Road, Ann Arbor, MI 48105; phone 313/994-8168.

The **Infant Development Association,** the **National Center for Clinical Infant Programs, six California state agencies** concerned with young children and families, and other professional and community organizations will sponsor a national conference May 11-13, 1989 in Los Angeles, California. The conference theme is "Moving from Research to Practice: Directions for Implementing Infant Services in the Nineties." To receive a copy of the conference call for papers, write to Karen Finello, Infant Conference '89, UAP-CHLA, P.O. Box 54700, Los Angeles, CA 90054.

The **Journal of Creativity Research,** which will publish its inaugural issue in December, 1988, anticipates a special issue in 1989 devoted to the developmental approach to the study of creativity. Reports from empirical studies and theoretical papers are invited. For information, contact Mark Runco, Editor, The Journal of Creativity Research, EC 105, California State University, Fullerton, CA 92634, tel: (714) 773-3861.

Children's Environments Quarterly invites manuscripts for two special issues. Submissions for the Summer 1989 issue on "Day Care Environments: Policy Research and Design" are due **December 30, 1988.** Submissions for the Fall 1989 issue on "Design for Children with Physical and Sensory Disabilities" are due **February 1, 1989.** For submission guidelines, contact Children's Environments Quarterly, Environmental Psychology Program, CUNY Graduate School and University Center, 33 West 42 Street, New York, NY 10036, tel: (212) 944-235.

Publications

Early Intervention for Infants and Children with Handicaps: An Empirical Base (1988)—Samuel Odom and Merle Karnes, editors (Brookes Publishing Co., P.O. Box 10624, Baltimore, MD 21285-0624) $37.00.

The sixteen chapters of this book, a product of two committees within the Division for Early Childhood of the Council for Exceptional Children, were solicited to address four topical areas: 1) issues related to conducting research with infants and young children with handicaps; 2) research on instruction or intervention practices within "developmental skill domains" (including language and social interaction); 3) issues related to families; and 4) other salient issues including mainstreaming, the impact of home-based early intervention, and training of early childhood special educators. Contributors to the volume include Stephen Bagnato, Donald Bailey, Patricia Barber, Shirley Behr, Jeffri Brooksfield-Norman, Judith Carla, Glendon Casto, Eugene Edgar, Rebecca Fewell, Charles Greenwood, Michael Guralnick, Lawrence J. Johnson, Ann Kaiser, Ruth Kaminski, Merle Karnes, Georgia Kerns, Frank Kohler, Kathleen McCartan, Jeanette McCollum, Mary McEvoy, John Neisworth, Samuel Odom, Cordelia Robinson, Steven Rosenberg, Diane Sainato, Rune Simeonson, Phillip Strain, Ann Turnbull, Steven Warren and Mark Wolery.

Parent-Infant Habilitation: A Comprehensive Approach to Working with Hearing Impaired Infants and Toddlers and Their Families (1987)—Valerie Schuyler and Nancy Rushmer (Infant Hearing Resource, Good Samaritan Hospital and Medical Center, 1015 NW 22nd Avenue, Portland, OR 97210) $39.50 plus $4 postage and handling.

In most programs which train teachers of the hearing impaired, note the authors of this volume, the emphasis is on providing the prospective teacher with skills for instructing children. But the parent-infant specialist, the authors suggest, must make a mental adjustment, re-directing the focus of her attention to the parents; her feelings of competence and accomplishment are derived from parent achievement, which results in achievement on the part of the child.

This 558-page text describes in detail the approach and methods used by staff of the Infant Hearing Resource program in Portland, Oregon, in working wtih hearing impaired infants and their parents. In addition to describing techniques specific to work with hearing-impaired children, chapters address issues (with many case illustrations) that can be applied to a variety of settings serving infants and toddlers with disabilities and their families. These include establishing a framework for habilitation, establishing the parent-specialist partnership, attending to the feelings and needs of parents, helping parents learn to observe and report their child's behavior, helping parents promote their child's self-esteem, and working with multi-handicapped young children. Special attention is given to beginning work with a family. The authors observe that "when a newly enrolled infant crawls through the door of an agency for the first time, he is followed by anxious parents who may want to know and do everything at once in order to fix this newly diagnosed problem or by parents who may want to know and do nothing because they are hurting too much to act. The specialist can, at this point, be an anchor of stability."

Assessment of Young Developmentally Disabled Children (1988)—Theodore D. Wachs and Robert Sheehan, editors (Plenum Press, 233 Spring Street, New York, NY 10013) $49.50.

The editors of this volume define the assessment of early development as "the systematic, purposeful collection of data, reflecting both patterns of children's emergent abilities to comprehend and function in their environment and the factors associated with the emergence of these patterns." The book is designed to provide clinicians with support for the use of assessment data in planning early intervention.

In an effort to ensure an integration of major concepts throughout the book, the editors circulated chapters describing developmental patterns of young children with disabilities, elements of the assessment process, instrument selection, clinical considerations in the assessment of young handicapped children, and the involvement of parents in assessment to contributors writing about the specifics of cognitive assessment with young children with various handicapping conditions and to authors discussing non-cognitive assessment—e.g., the assessment of motoric behavior, temperament, motivation, language, and environmental and biophysical assessment. A section entitled "From Assessment to Intervention" highlights the use of decision rules, the need for carefully articulated assessment purposes, the need for an assessment of *learning* (as well as of performance), and the need for a broad range of assessment efforts; these are seen as themes to be incorporated into practice. Donald Bailey, Kathryn Barnard, Carl Dunst, Robert Harmon, Cordelia Robinson, Robert Sheehan, Rune Simeonsson, Vaughan Stagg and Theodore Wachs are among the 26 contributors to the book.

Sensitivities, Skills and Services: Mental Health Roles in the Implementation of Part H of P.L. 99-457 (1988)—prepared by Emily Schrag (Child and Adolescent Service System Program [CASSP] Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Road, N.W., CG-52, Washington, D.C. 20057) $4.00.

This 20-page issues paper summarizes the discussion of a group of administrators, clinicians, policymakers and parent representatives called together in December, 1987 by the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health. The publication addresses: 1) the population of infants and toddlers who should receive mental health attention and services through P.L. 99-457 and other programs; 2) elements of a continuum of mental health services; and 3) possible roles and responsibilities for mental health professionals and agencies serving infants, toddlers and their families within the framework of P.L. 99-457.

The Ordinary Is Extraordinary: How Children under Three Learn (1988)—Amy Laura Dombro and Leah Wallach (Simon and Schuster, 1230 Avenue of the Americas, New York, NY 10020) $17.95.

In this volume, the former head of the infant/toddler day care center at the Bank Street College of Education in New York points out to parents and professionals who may be obsessed with the notion of "quality time" that "everyday activities are . . . the best opportunities for learning you can give your child and the most important time you can spend with her, because her chief task in her first three years is precisely to gain command of the day-to-day life you take for granted."

Dombro emphasizes the opportunities for practice provided by the routine activities of personal care, household chores, ventures into the outside world, and contacts with adults other than parents. She also illustrates how daily activities are a source of different kinds of learning at each stage in a young child's development. Typical scenes between young children and their parents are analyzed in terms of what the children are learning about the physical environment, people in their world, ideas and words, and their own sense of self.

Children, Families and Cities: Programs That Work at the Local Level (1987)—John E. Kyle, editor (Publications Office, National League of Cities, 1301 Pennsylvania Avenue, N.W., Washington, D.C. 20004) $15.00 plus $2.00 for postage and handling. Bulk rates available.

This 200-page volume presents 32 case studies of successful local programs that provide services and assistance to children and families in the areas of strategic planning and coordination, child care, youth employment, child and family homelessness, and adolescent pregnancy prevention. Among the programs described are the Pittsburgh Foundation and The Howard Heinz Endowment; the comprehensive child care program of Seattle, Washington; the Consortium for Services to Homeless Families in Washington, D.C.; and the Hartford Action Plan on Infant Health, Inc.

The editor derives 12 principles from the programs profiled in the book which might guide local programs and policies: 1) leadership is crucial; 2) vital and reliable facts about a problem are needed; 3) public-private partnerships strengthen the efforts of all involved; 4) worthwhile efforts must be institutionalized for lasting impact; 5) services must be coordinated; 6) high visibility ensures ownership; 7) communities and/or neighborhoods should be involved in both policy making and program delivery; 8) schools and school systems have a crucial role; 9) evaluation is important for program development and accountability; 10) children, families and their interaction must be considered in child and family policy approaches; 11) the impact on children and families of *all* local policies must be considered; and 12) the issue of prevention must be included in the planning of services.

Programs to Strengthen Families: A Resource Guide (revised edition 1988)—Carole Levine, editor (Family Resource Coalition, 230 North Michigan Avenue, Suite 1625, Chicago, IL 60601) $12.50.

This second edition of *Programs to Strengthen Families* (the first was published in 1983) is designed to reflect the state of the art in family support programs, defined as "offering preventive, community-based, non-deficit programs that empower all families." Seventy-two programs, grouped into ten categories, are described; each program has been in existence for a number of years, has been evaluated formally or informally, and has either been replicated or has been a source of information for emerging programs.

The editor points out that 41 of the 72 programs included in the original edition of *Programs to Strengthen Families* are described in the current edition. Several of the 1983 programs were established as demonstration or research efforts and were terminated by design; many were unable to sustain themselves during the five years since 1983; and a small number of programs could not be located.

The prenatal, infant and toddler programs described include Birth to Three (Eugene, Oregon); COPE (Boston): Early Childhood Center, Cedars-Sinai Medical center (Los Angeles); The Family Place, Inc. (Washington, D.C.): Infant Care Programs, Evanston Hospital (Evanston, Illinois); Parenting Program, J.B. Franklin Maternity Hospital (Philadelphia); Parents of Prematures (Houston, Texas); and Birth Resource Center (Santa Barbara, California).

Help Wanted

The Fatherhood Project, a national research demonstration and dissemination project designed to encourage wider options for male involvement in childrearing, is updating and expanding its 1984 resource book, *Fatherhood U.S.A.*, to be released by Fathers' Day 1989. Information is sought on programs and services for fathers or potential fathers; books, brochures and newsletters; films and videos; and other resources. Respondents are asked to send descriptions and examples of resources, along with one or two paragraphs highlighting the most interesting facet of their work with fathers. Write or call James Levine, Director, The Fatherhood Project, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 663-7200.

Gary Moore and Lou-Ann Bunker-Hellmich of the **School of Architecture and Urban Planning, The University of Wisconsin, Milwaukee,** are preparing a review article on the developmental impact of the physical environment for Volume 24 of *Advances in Child Development and Behavior*. Especially relevant is research on the impacts of hospital environments on child development and behavior, educational environments including child care centers and classrooms, playgrounds and other recreational environments, housing and other urban settings including neighborhoods, environmental cognition, health hazards and safety, noise, density and crowding, theory and method, and examples of novel and/or successful environments and empirically based environmental standards and guidelines. Please send materials to Dr. Moore and Ms. Bunker-Hellmich at the Center for Architecture and Urban Planning Research, University of Wisconsin-Milwaukee, WI 53201-0413.

The clinical staff of **Bienvenidos Children's Center, Inc. (BCC)** in West Covina, California, are interested in collaborating with academics and clinicians on research concerning infants and toddlers in emergency shelter care. Licensed by the State of California as a Group Home, BCC provides protective care for children 0-3 who are victims of physical and sexual abuse, abandonment or neglect and is exploring the possibility of serving medically vulnerable children. Direct inquiries to Joan Coyner, Director of Social Work, Bienvenidos Children's Center, Inc., 421 South Glendora Avenue, West Covina, CA 91790, tel: (818) 919-3364.

The "Kids Project" of the **National League of Cities** will use surveys, studies of selected cities and other information to develop new publications, data bases for information sharing, technical assistance and conference workshops, all designed to help local government officials to become more responsive to the special needs of children and families. John E. Kyle, former director of the Office for Children and Youth for the State of Maryland and editor of NLC's *Children, Families and Cities*, will direct the "Kids Project," which has been funded by grants from the Lilly Endowment, Carnegie Corporation and the Rockefeller Foundation. Individuals and organizations interested in becoming involved with the project should contact John Kyle at the Office of Policy Analysis, National League of Cities, 1301 Pennsylvania Avenue, N.W., Washington, D.C. 20004, tel: (202) 626-3030.

Conference Call

October, 1988

October 8-11: The *National Perinatal Association* will sponsor a clinical conference and exhibition, entitled "Perinatal Health Care: Facing the 21st Century," in San Diego, California. Plenary speakers will include T. Berry Brazelton, C. Arden Miller, Mary Ellen Avery, Arthur J. Ammann, Ronald Chez, John Paris, Katharyn Antle May, Graham Liggins, David Rimoin, Marian Wright Edelman and Robert Gale. For information contact NPA, 101-½ South Union Street, Alexandria, VA 22314-3323, tel: (703) 549-5523.

October 12-14: The *National Black Child Development Institute* will hold its 18th annual conference, entitled "Empowerment: An Imperative for Black Children and Families," in Los Angeles, California. Speakers will include The Honorable Augustus Hawkins, Roselyn Epps, Betty Hutchinson, Asa Hilliard, Gina Barclay-McLaughlin, and Pamela Hubbard-Wiley, among others. Write or call NBCDI, 1463 Rhode Island Avenue, N.W., Washington, D.C. 20005, tel: (202) 387-1281.

October 13-15: The fourth annual *Pediatric Nursing Conference* will take place in Chicago, Illinois, addressing the theme "Bridging the Gap between Primary and Acute Care: Transitions from Hospital to Home." Speakers will include Donna Wong, Arthur Kohrman, Robert Sweeney, Elizabeth Hogue, Joanne Kaufman, Nia Johnson-Crowley and Nancy Lodding, among others. For information, contact Anthony J. Jannetti, Inc., North Woodbury Road, Box 56, Pitman, NJ 08071, tel: (609) 589-2319.

October 14: The *Illinois Association for Infant Mental Health* will hold its sixth annual conference in Chicago, on the theme "Against All Odds: Bringing Success into the Lives of Multirisk Infants and Families." Alicia Lieberman will be the keynote speaker. For information, contact Barbra Lancelot, Illinois Institute for Developmental Disabilities, 1640 West Roosevelt Road, Chicago, IL 60608, tel: (312) 413-1567.

October 14-15: The *Center for Infant Study, University of Maryland School of Medicine* will sponsor a symposium in Baltimore, Maryland on "The Roots of Creativity in Infancy: The Beginnings of Imaginative Life." Speakers wil include E. James Anthony, T. Berry Brazelton, Justin Call, E. Virginia Demos, Jerome Kagan, Lewis Lipsitt, Taghi Modarressi, Arnold Modell, Arnold Sameroff and Endora Welty. Write or call Sharon Steinhouse, Program of Continuing Education, University of Maryland, School of Medicine, 655 W. Baltimore Street, Room 14-011, Baltimore, MD 21201, tel: (301) 328-3956.

October 17-19: The *National Family Based Services Conference*, entitled "Empowering Families '88," will be held in Boise, Idaho. Featured speakers will include Michael Petit, Evan Imber-Black, and Nancy Amider. For further information contact Alan Himsl, Idaho Department of Health and Welfare, Statehouse Mail, Boise, ID 83720, tel: (208) 334-5700.

October 27-30: The *American Association for Marriage and Family Therapy* will hold its 46th annual conference in New Orleans, Louisiana. Presenters will include Mavis Hetherington, Evan Imber-Black, and Monica McGoldrick, among 600 family therapists presenting. Contact AAMFT Conference, 1717 K Street, N.W., #407, Washington, D.C. 20006, tel: (202) 429-1825.

November, 1988

November 2-4: *Contemporary Forums* will hold the fourth annual conference on "Developmental Interventions in Neonatal Care" in San Diego, California. Conference faculty include Heidelise Als, Leila Beckwith, T. Berry Brazelton, Joy Browne, Ronald David, Suzanne Dixon, Susan Fowler, Linda Franck, Peter Gorski, Tim Healey, Elise Holloway, Judy Howard, Robert Kettrick, Marshall Klaus, Gretchen Lowhon, Alicia Lieberman, Marjorie Palmer, Lu-Ann Papile, Kathy Petersen, Kathleen VandenBerg and Robert White. Contact Contemporary Forums, 530 La Gonda Way, Suite E, Danville, CA 94526, tel: (415) 820-2800.

November 2-5: The *American Association for Protecting Children* will sponsor its 112th annual meeting, entitled "Protecting Children—Charting the Course," in Tacoma, Washington. Topics to be addressed include integration of children's services, protecting developmentally disabled children, training and certification issues, the use of research findings, and drug addicted families, among other issues. For more information, write to Debbie Freeman, American Association for Protecting Children, American Humane, 9725 East Hampden Avenue, Denver, CO 80231-4919.

November 4-5: The *Boston Institute for the Development of Infants and Parents, Inc.* will hold its 13th annual conference, entitled "Clinical Applications of Research in Infant/Parent Relationships," in Boston, Massachusetts. Emily Schrag will be a keynote speaker. Panels and seminars wil address homelessness and young children, early intervention, custody issues, sleep disturbances, attachment behavior, the development of young blind children, AIDS, and other topics. Write or call A.M. Kerzner, BIDIP, 26 Trapelo Road, Belmont, MA 02178, tel: (617) 484-6603.

November 13-16: The *Council for Exceptional Children's Division for Early Childhood* will sponsor an International Early Childhood Conference on Children with Special Needs, to be held in Nashville, Tennessee. Frances Degen Horowitz and Michael Guralnick will give plenary addresses. For information, write to Division for Early Childhood, The Council for Exceptional Children, 1920 Association Drive, Reston, VA 22091.

November 16-19: *Harvard Medical School, Harvard School of Public Health* and *Cambridge Hospital* will sponsor a course in Boston, Massachusetts entitled "Children and Society: Policy Context for Clinical Practice." Major themes will include access to health care for mothers and children, infancy and childhood, and children's rights to day care, health care and protective care. Faculty include Robert Coles, Joy Dryfoos, Stephen Joseph, Richard Klein, Marie McCormick, Julius Richmond, Lisbeth Schorr and Heather Weiss, among others. For further information, write or call Harvard MED-CME, P.O. Box 825, Boston, MA 02117, tel: (617) 732-1525.

November 17-18: The *U.S. Department of Education* will sponsor a national conference in Washington, D.C. on "Early Childhood Issues: Policy Options in Support of Children and Families." Debates among members of Congress concerning child and family-related legislation will be scheduled. Infant/toddler day care and early intervention will be topics of panel sessions. For information call Dr. Pat Kinney, tel: (703) 684-5588.

November 17-20: The *National Association for Perinatal Addiction Research and Education (NAPARE)* and the *Office for Substance Abuse Prevention* will sponsor a national training forum in Los Angeles, California entitled "Drugs, Alcohol, Pregnancy and Parenting." Keynote speakers will include T. Berry Brazelton, Robert Cefalo, Ira J. Chasnoff, Christina Crawford, Clara "Mother" Hale, Lorraine Hale, Hon. Donald Ian MacDonald and Albert J. Solnit. For information, write to NAPARE, 11 East Hubbard Street, Suite 200, Chicago, IL 60611.

Zero to Three

is published 5 times per year. Subscriptions costs $18 per year, $35 for 2 years and $45 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $5/auxiliary subscription/year.

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Standards of Practice and the Pain of Premature Infants

by
Jill R. Lawson
Silver Spring, Maryland

Our son Jeffrey was born in February, 1985, at 25-26 weeks' gestational age, weighing one pound eleven-and-a-half ounces (760 grams). He was responsive with Apgar scores of 3 and 7, but he was very sick. He was immediately placed on a respirator. He developed several lung disorders, a moderate brain bleed, and kidney and liver problems. After two weeks, an artery intended to help a fetus's circulatory system bypass the lungs while still in the womb wasn't closing as it should. So Jeffrey was transferred from Columbia Hospital for Women to Children' Hospital/National Medical Center for patent ductus arteriosus surgery. (PDA surgery is the most common operation performed on preemies.) At the same time he was to have implanted in his chest a semi-permanent secure catheter to deliver liquids and medications when regular intravenous lines are difficult to maintain.

On the morning of surgery, which had been scheduled three days in advance, Jeffrey became somewhat unstable when taken to the operating suite. He was not moribund. He was not comatose. He was still, as the transport team had described, " a very small pink male ... very active ... with appropriate responses and gestures." This was not rushed, emergency surgery but rather surgery scheduled to increase the likelihood of improvement over a length of time. In spite of this, the anesthesiologist decided the operation would proceed without delay, and she paralyzed him, using no pain relief or anesthesia of any type either before, during or after surgery. It was beside the point that I had been promised before I signed consent forms that Jeffrey would be given general anesthesia. And somehow it was possible for professionals who perceived a baby as too fragile to tolerate general anesthesia to perceive that same infant as able to withstand open-chest surgery without pain relief.

ROBERT MAUST

My husband and I were not told of these decisions, even though one of us was present most of the time, including before and during surgery. On the contrary, on two successive occasions after the surgery, Jeffrey's nurses told us that he was so still because his anesthesia was still wearing off.

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Jeffrey died five weeks after surgery. Shortly before his death, a nurse friend had mentioned that there was a time when babies were not anesthesized for surgery. After recovering from my own baby's death, I called his doctor for reassurance.

Instead the anesthesiologist informed me that she had not used any anesthesia or analgesia on Jeffrey. He had only been given a paralyzing agent called Pancuronium bromide (Pavulon). She said it had never been demonstrated that babies can feel pain, and that it had not occurred to her to use alternate methods of pain control after she ruled out general anesthesia. She also told me Jeff's blood pressure had been too low to tolerate anesthesia (other physicians who have reviewed his records have concluded that his pressure was satisfactory for a preemie that size).

The anesthesiologist never told our son's surgeon that she was going to withhold anesthesia. Therefore he never had a chance to make an informed decision, just as we the parents never had a chance to make an informed decision.

The anesthesiologist's department chairman defended her by claiming that Jeffrey's pain was comparable to the discomfort experienced when a patient has a tube placed down his throat, and also that chemicals produced in the brain under stress should have been sufficient to mask deep pain. But I learned later that the cerebrospinal fluid levels of such endorphins required to mask pain in human adults are 10,000 times higher than the highest recorded levels in newborns (Foley, Kourides, Inturrisi, et al., 1979).

And Jeffrey endured more than having a tube placed down his throat, which is usually a five-minute procedure. For 1½ hours he had holes cut on either side of his neck, another hole cut in his right chest, a catheter inserted in his jugular vein, and these holes stitched shut. We were told by the surgeon afterward that they had trouble securing the catheter, so they repeated that procedure. Next Jeffrey was cut open from his breastbone around to his backbone. Then his flesh was lifted aside, his ribs pried apart, his left lung retracted, and the blood vessel near his heart was tied off. Then the tissues were stitched together in layers and a final "stab incision" made in his left side to insert a new chest tube.

Jeffrey's surgical charts indicate that when he was cut open, his blood pressure, pulse rate and oxygen requirements all jumped, classic signposts for pain. After surgery his pulse and pressure remained elevated for two days before subsiding to previous levels.

The night following surgery Jeffrey's lab test results went haywire. The resident on duty called us and said that Jeffrey might die before morning since his body had started to digest itself (catabolism) due to stress and shock. He had to be resuscitated as his heart, kidneys and liver failed due to the kind of severe chemical imbalance described by Drs. Anand and Hickey (1987) among infants unprotected from pain during PDA surgery. His dependence on his respirator increased and his brain bleed worsened.

Later, when I met informally with hospital staff, Jeffrey's anesthesiologist represented to me that Pavulon could be construed as affording some pain relief. But Pavulon has no effect on pain. In addition, adult patients who have been given this agent report discomfort caused by Pavulon itself, notably prolonged sensation of drowning in one's own saliva. Besides that, Pavulon can create side effects as potentially harmful as some anesthetics (Taylor, 1980).

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When I asked why the operation proceeded without waiting till Jeffrey was having a better day, if that was indeed the problem, the anesthesiologist replied that such decisions are up to the surgeon. But she never told the surgeon that she was going to withhold anesthesia. I was the one to tell him, five months later. Therefore he never had a chance to make an informed decision, just as we the parents never had a chance to make an informed decision.

The anesthesiologist also presented the changes in pulse and pressure by claiming that they only increased after the artery was ligated and that this was welcome evidence of increased circulatory capability. But the chart shows the biggest jump occurred when Jeffrey's chest was cut open, not after ligation. And since his pulse and pressure subsided to previous levels two days later and remained down till he died, her claims don't make sense to me.

I can remember assuming that if I called people's attention to the facts, everyone would see that this doctor should never practice medicine again. I was wrong. I discovered instead that Jeffrey's maltreatment wasn't due to one individual's aberration.

After these initial contacts with the physicians involved, I can remember assuming that all that remained to be done was to call people's attention to the facts and then everyone would see that this doctor should never practice medicine again. I was wrong.

I discovered, instead, that Jeffrey's maltreatment wasn't due to one individual's aberration; rather it happened frequently.

The Chairman of the Committee on Fetus and Newborn of the American Academy of Pediatrics wrote that "We did a small survey of neonatal units around the country about this issue. We found that there are still some units that regularly operate on the smallest, sickest premature infants using the same technique that your son experienced (Poland, 1986). A researcher at the University of Iowa's College of Nursing who had given more than 100 presentations on the topic of children's pain wrote that nurses in her audiences who worked with infants and premature infants in hospitals around the country reported that, with *very rare* exceptions, *no* anesthesia was the rule, rather than the exception for surgical procedures (Eland, 1987, emphasis in original). Such awareness was fairly common among doctors, nurses and technicians. A second friend and my stepmother, both former nurses, said, "Oh, yeah, I knew about that," as soon as I told them what I had discovered.

When I went to the National Library of Medicine, even though I had never seen medical literature before, within two hours I found three articles detailing PDA surgery on infants without pain relief. Two noted current practices of using no anesthesia and then outlined success using fentanyl anesthesia. The third article advocated only that, "The surgical procedure is safely accomplished with oxygen and pancuronium as the sole agents" (Wesson, 1982). I also discovered through other articles that reputable physicians writing in reputable journals had taken, and quite passionately, opposing positions on the existence of infant pain. The literature also revealed that reasonable safe, potent anesthetics had been available for five years for even the smallest preemies (Berry and Gregory, 1987). But many pediatric anesthesiologists, surgeons and even some neonatologists made the decision not to use them. This is in contrast to the fact that adults are uniformly given anesthesia/analgesia even though this is acknowledged as the riskiest part of surgery. We accept these substantial risks to avoid inordinate suffering.

Editors note:

The suffering of babies can be almost unbearable for adults to witness, or event to think about. As professionals, as parents, as human beings, we want to bring immediate comfort to a child in pain. If we cannot, our sense of helplessness may lead us to remove ourselves from the infant's pain, physically or psychologically.

The articles in this issue of *Zero to Three* do not let us escape from acknowledging the pain of very young children. But the authors also suggest ways to bring comfort—some that are older than humankind itself, some that reflect the latest medical discoveries. Jill Lawson, Ronald Poland, Rosemary Campos, David Howell and Lois Murphy all remind us of the importance of "staying near" the infant or child in pain. Our presence itself may be a comfort, but that is not the only reason to stay near. Only by remaining near will we be forced to see the pain of babies—even what we cannot fix, even what we ourselves have caused. Only by remaining near will we be able to learn, and, perhaps, to understand and to change.

Following my search of the literature and my meeting with staff at Children's Hospital, I consulted with two attorneys. They concluded that there are no laws extant requiring doctors to mitigate pain and that unquestionably the doctor involved met "standards of practice."

Then I approached many medical groups, advocacy associations and individuals for help. Most either declined to help or supported the doctor's actions. These include, but are not limited to, the District of Columbia Board of Medicine, which is the local licensing and regulatory agency; the Medical Society of D.C., which wrote that

> It appears there is controversy in the literature about the appropriate form of anesthesia for small infants and that the transmission of neuro-impulses in such a young child may not be sensed as pain in an immaturely developed brain. The patient may not sense the pain as such.

> The anesthesiologist must balance the risks of using anesthesia versus allowing possible pain. In Dr. _________'s judgment, it was far safer for the patient to undergo the surgery with close observation and monitoring. It appears she was dealing with a difficult anesthesia situation in a very sick child and that she acted ethically and in good faith with the best interests of your child in mind. (Barr, 1986);

also the American Civil Liberties Union, to whom I appealed they try Jeffrey's case on an age-discrmination basis; our medical insurance plan, whom I asked to apply financial pressure to hospitals to use humane methods; the American Pain Society; the Hastings Center Report, a publication concerned with bioethical issues, which declined to print anything on the subject on the basis that it was not sufficiently concerned with ethics; even "Dear Abby," who said the doctor must know best and that this didn't have anything to do with vivisection, which she opposes; the Council on Ethical and Judicial Affairs of the American Medical Association; the AMA's section on Medical Science and Education; the Joseph & Rose Kennedy Institute of Ethics at Georgetown University; the American Board of Anesthesiology; the American Society of Anesthesiologists; Children's Hospital's patient representative, who asked whether I was getting psychological help when I complained; the U.S. Department of Justice Baby Doe unit, which had listed cruel and unusual treatment as one of its three criteria for intervention; the D.C. Child Welfare Division; the D.C. Parents of Preemies support group, whose then president declined to get involved on the grounds that parents would rather not know about this; the Office for Civil Rights of the U.S. Department of Health and Human Services; the U.S. Surgeon General, himself a pediatric surgeon; the Children's Defense Fund; the U.S. House of Representatives Select Committee on Children, Youth, and Families; the National Committee for the Prevention of Child Abuse; the National Perinatal Association; and the then Chairman of the Section on Anesthesiology of the American Academy of Pediatrics.

One mother said to me, "I never thought to inquire about anesthesia. I'd as soon have asked if the surgeon was planning to wash his hands before the operation."

One of the more disturbing experiences in this process was the comment made to me by the senior neonatologist on staff at Children's Hospital. At a meeting concerning Jeffrey's treatment, he said that what happened to my son didn't matter because he was a fetus. When I asked how old someone has to be to feel pain, he placed the line of demarcation at about two years.

Other parents tell the same story. Cases which are a matter of record include Carmen Machado, who "survived six brain surgeries, often without the benefit of anesthesia (Machado, 1985);" Jacob Schrag, who died during abdominal surgery for necrotizing entercolitis without anesthesia in Oakland, California in April, 1988 (Stern); Michael Londner, who had two brain surgeries without anesthesia in Miami, Florida in late 1981 (Londner, 1988). There are other cases too. In most instances parents checked their babies' records after reading about Jeffrey, and in that process they learned for the first time what had been done to their children.

Ultimately my son's story attracted national and international attention. People started talking about the issues, and a few remarkable individuals and groups did effect changes.

As one mother said to me, "I never thought to inquire about anesthesia. I'd as soon have asked if the surgeon was planning to wash his hands before the operation" (Londner). The only case in which the doctor told the parents ahead of time was Carmen Machado's, whose mother was threatened with legal action by the hospital if she refused to consent to her daughter's unanesthesized surgery.

Ultimately my son's story, and the lack of remedy afforded by our medical community, attracted national and international attention. People started talking about the issues, and a few remarkable individuals and groups did effect changes. The first article appeared simultaneously in the popular press and in a medical journal in November, 1985 (Scanlon). In June, 1986, the Journal *Birth* printed my letter concerning surgery on infants without anesthesia. In August, 1986, the *Washington Post* printed a feature article which was carried over UPI wires and reprinted in several major city newspapers. That article in turn was picked up by Cable News Network, which provided extensive coverage of this issue the week of October 17, 1986. That coverage was discussed and shown at the American Society of Anesthesiologists' annual conference the next week, and at about the same time I received word from Dr. Ronald L. Poland that the American Academy of Pediatrics was going to bring out a policy statement. The American popular and medical specialty press generated a total of seventeen articles and television segments about our son's treatment. Recently there has been a flood of publications and conferences on the whole topic of pediatric pain control, most of it positive.

The resolution of the American Academy of Pediatrics detailing the new consensus protecting infants from unnecessary pain during surgery was published in the September, 1987 issue of *Pediatrics,* endorsed unanimously by the House of Delegates of the American Society of Anesthesiologists at its annual conference in October, 1987, and printed in the ASA's Newsletter in December, 1987. Children's Hospital staff are now using painkillers on most, if not all, babies (Fletcher, 1987). And Dr. Anand was invited to speak there this past summer.

I feel heartened by the response from concerned individuals and by evidence of a positive change in professional and public awareness since our son's surgery. But I know human nature well enough to realize that people change slowly, and some people never change. A consensus that is only theoretical doesn't help patients. Nance Butler (in press) has described some of the factors which exert a powerful influence on physicians and which result in their not accepting anesthesia for infants. So, for at least the next few years, some babies will still suffer unnecessarily.

The doctor who failed to mitigate the pain of our son also caused our whole family pain. We have to remember Jeffrey with a world of hurt. Our son is dead, and we can live with that. What is so hard to live with is his life. The doctor who "anesthetized" Jeffrey diminished his quality of life and his chances for survival. Nothing can undo that or bring him back to us.

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Neonatal Anesthesia: Statement by the American Academy of Pediatrics and the American Society of Anesthesiologists

As Jill Lawson notes in her article, the September, 1987 issue of *Pediatrics*, journal of the American Academy of Pediatrics, contained a statement on neonatal anesthesia by its Committee on Fetus and Newborn, Committee on Drugs, Section on Anesthesiology and Section on Surgery. The House of Delegates of the American Society of Anesthesiologists joined the American Academy of Pediatrics in approving the statement, which was published in the ASA Newsletter of December, 1987. The full text of the statement, from *Pediatrics*, Volume 80, No. 3, p. 446, is reproduced below, with permission.

According to Ronald L. Poland, M.D., Chairman of AAP's Committee on Fetus and Newborn, this statement is the result of a process that began with a letter from Ms. Lawson to the American Society of Anesthesiologists. Brought to the attention of the AAP's Committee on Fetus and Newborn, the letter prompted a review of current practice and a recognition that significant changes should be made in the way pain relief is administered to newborns undergoing surgical procedures.

In a letter to Ms. Lawson enclosing the statement from *Pediatrics*, Dr. Poland wrote:

"Your efforts led directly to this result. I congratulate you for your sane and constructive work for the benefit of children everywhere. It would have been very understandable if you had reacted differently ....

We are all very grateful that you brought the issue to light and did not give up on the medical profession. I am very pleased to have been a part of the process."

STATEMENT ON NEONATAL ANESTHESIA

In the past, some practicing physicians have advocated withholding anesthetic or analgesic agents from neonates undergoing surgical procedures. The rationale expressed for such practice is that some neonates undergoing surgery are often so unstable that the risk of an anesthetic agent is too great to justify the possible benefit of pain relief. An analogy may be drawn to the adult patient with major trauma who must undergo life-saving surgery in whom anesthesia has been reduced or withheld because of the fear of worsening an already compromised physiologic homeostasis.[1] Also cited in support of this practice is the impression that nerve pathways are not sufficiently myelinated to transmit painful stimuli or that neonates do not have sufficiently integrated cortical function to recall painful experiences.

There is an increasing body of evidence that neonates, including those born preterm, demonstrate physiologic responses to surgical procedures that are similar to those demonstrated by adults and that these responses can be lessened with anesthetic agents.[2-6] Other studies have suggested that stability of variables such as blood

presure, heart rate, and oxygenation is important in reducing complications such as intraventricular hemorrhage or pulmonary hypertension.[7,8] There is also increasing evidence that neonatal cortical function is far greater than previously thought [9,10] and some suggestion that short-term behavior may be affected by prior painful stimuli.[11, 12]

The Committee on Fetus and Newborn, The Committee on Drugs, the Section on Anesthesiology and the Section on Surgery believe that local or systemic pharmacologic agents now available permit relatively safe administration of anesthesia or analgesia to neonates undergoing surgical procedures and that such administration is indicated according to the usual guidelines for the administration of anesthesia to high-risk, potentially unstable patients. In occasional situations, physiologic instability will be so great that the anesthetic agents must be reduced or discontinued. However, the decision to withhold such medication should be based on the same medical criteria used for older patients. The decision should not be based solely on the infant's age or perceived degree of cortical maturity.

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Comfort Measures for Infant Pain

by

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A disturbing contradiction exists in infant health care today. Impressive advances are being made in saving the lives of small infants, but progress in ensuring that these infants receive humane care is slow. The physiological status of premature infants is continuously monitored, but grimaces, agitation and other signs of pain are poorly documented. Newborns throughout the country are screened for rare genetically transmitted illnesses, but the pain cries that accompany the testing of those infants are routinely ignored. Parents are carefully instructed on how to feed their babies, but they are given no information on how to identify or relieve their baby's pain. In sum, contemporary neonatal care is impressively reducing morbidity and mortality but now needs to address the important, unresolved issue of infant pain

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It is the thesis of this article that infants indeed experience pain in adult-like fashion, and that behavioral and environmental interventions can markedly influence the quality of experience an infant has when undergoing painful but necessary medical and nursing interventions.

Until recently, there has been a widely held belief that infants either do not experience pain at all, or are very insensitive to painful stimuli. One of the most important bases for this widespread belief came from an early study of reactions to repeated pin pricks in 75 children (McGraw, 1941). Neonates in this study exhibited only diffuse body movements to the painful stimulus. It was not until the infants were six months of age that they showed active avoidance and anticipatory withdrawal. On the basis of these findings, McGraw concluded that newborns were relatively insensitive to pain. Other empirical studies by Gullickson and Crowell (1964), and before them by Sherman and Sherman (1925) further demonstrated relatively high thresholds to stimulation or pin pricks in early infancy. These findings led authors of influential textbooks like Munn (1965) to conclude that at birth, there is no clear evidence of pain sensitivity.

Theoretical considerations from evolutionary and psychoanalytic theories further buttressed the belief that infants were insensitive to pain. Many authorities proposed that it is biologically advantageous for the neonate to have high thresholds because of the excessive painful encounters the baby has to go through during the perinatal period. Psychoanalytic theory proposed the concept of the "stimulus barrier," which is a protective device to keep excessive stimulation from overwhelming the immature ego of the neonate.

Furthermore, practical considerations made it easier for health professionals to act as if neonates do not of the palm of the hand is soothing, whereas light finger tip stimulation is arousing.

4. **The principle of vestibular stimulation.** Soothing interventions which incorporate vestibular stimulation are especially effective in calming infants. Placing the infant at the shoulder facilitates soothing and visual attentiveness because of the vestibular-proprioceptive stimulation, not because of contact with the mother or upright positioning (Korner & Thoman, 1972).

5. **The principle of distraction:** If an infant can be given a source of stimulation on which to focus, the resulting activation of one sensory system can impede attention to input from another sensory system, such as the pain system. For instance, Wolff (1969) proposes that pacifying has soothing consequences because it interrupts the self-arousing cycle of crying and thrashing, and reduces the inflow of arousing peripheral self-stimulation of diffuse activity. Korner and Thoman (1972) have similarly argued that holding the infant upright is soothing because upright posture facilitates visual input, which can in turn compete with or inhibit noxious inputs.

6. **The principle of arousal transfer and relaxation.** This principle holds that arousal stemming from one source of stimulation can interact additively or multiplicatively with arousal from another source of stimulation to affect the intensity of an affective reaction. In other words, a child aroused by hunger or thirst will have a lowered threshold for arousal to painful stimulation. Alternatively, a child who is relaxed and calm will react with less intensity to negative stimulation than is a child who is already upset for other reasons. In general, then, reactions to stress can usually be minimized by generating the stress against a relaxed or non-aroused background state.

These principles of soothing have generally been derived in studies of infants who are not in states of pain. However, in recent years, the effectiveness of different soothing techniques for relieving pain-elicited distress has begun to be systematically investigated. What follows is a partial summary of the major findings to date on this topic.

Pacifiers

One of the most promising behavioral interventions for the relief of pain-induced distress is pacifying or non-nutritive sucking. Provision of oral stimulation is especially effective for infants in whom pain has produced high states of arousal. Administering a pacifier lessens the duration of crying, increases the amount of time in an alert/quiescent state, and reduces levels of physiological arousal.

More specifically, administering a pacifier to a group of two-week-old infants who received a heelstick led to interruption of crying within an average of 30 seconds in one study (Campos, in press). Another study showed that newborns administered a pacifier during circumcision showed 40% less crying than did controls (Gunnar, Fisch, & Malone, 1984). Healthy neonates and minimal-care preterm infants given a pacifier prior to and during a heelstick procedure spent more time in an alert/quiescent state both during and following the heelstick procedure than did control infants for whom a pacifier was not provided (Field & Goldson, 1984). The same study showed that pacifiers attenuated cardiac and respiratory reactions to the heelstick.

FLORENCE SHARP

The likely explanation for the effectiveness of sucking in reducing infant arousal is that it substitutes an organized response to stimulation—rhythmical sucking—for a disorganized, arousing response—diffuse motility (Kessen & Mandler, 1961). Since sucking is one of the few actions an infant can initiate, provision of a pacifier can distract the infant from painful stimuli. In addition, it is well known that exposure to cries can have very arousing effects on the central nervous system: by directly inhibiting the production of cries, pacifiers can break an arousal cycle. In this sense, the provision of pacifiers truly can enable the baby to exert control over his/her environment.

There is one important precaution to take when using pacifiers as soothers of infant pain. Premature removal of a pacifier can result in frustration and anger-like reactions in newborns and older infants (Bell, Weller, & Waldrop, 1971). The response to interruption of sucking is one of heightened tendency to cry. Consequently, if provision of pacifiers is the soothing method selected for stress reduction, it is important to provide a long opportunity for sucking, perhaps until the infant reaches a quiet sleep state, when it is relatively difficult to arouse the infant. Failure to retain the pacifier in the infant's mouth may result in the reinstatement of crying.

Rocking

Holding and rocking the infant is a frequent response of caregivers to the pain cries of their infants (Zeskind & Collins, 1987). It is typically the first strategy used by parents to calm their baby after administration of an immunization or heelstick, and it often appears to be effective in interrupting infant crying. Intermittent rocking while the infant is held upright usually results in cessation of crying and the establishment of a bright alert state, whereas continuous rocking while the infant is held horizontally induces a drowsy state (Byrne & Horowitz, 1981). Although the combination of rocking and holding has been successful in reducing arousal in mildly stressed infants (Byrne, & Horowitz, 1981), it is not clear whether this soothing method alone is sufficiently powerful to reduce high states of arousal elicited by pain. Nor is it clear how long the holding needs to last to promote long-term soothing, i.e. restoration of prestress levels of physiological arousal.

Contact

Picking up and holding the infant or child may be highly effective in soothing a crying infant because it provides not only tactile, but also vestibular stimulation (Korner & Thoman, 1972). Indeed, it is the most common response of caregivers to the cry of their baby. Surprisingly, though, not much work has been done evaluating the effectiveness of holding in reducing infant stress. One study did show that having the mother hold the infant during a blood drawing dramatically decreased the rate of crying in 2- and 12-week infants (Rieser, Green, McLaughlin, & Doxsey, 1982). The same study also reported that parental contact with the infant appeared to be especially important for young infants who were less adept at self-soothing. Some earlier but methodologically inadequate studies reported similar trends for holding the infant to reduce the intensity and duration of crying (Hallstrom, 1968). Although the issue is very relevant for health care professionals, the importance of touch by people other than the parents for soothing infants has not been systematically investigated.

Restraint of movement

One component of the soothing process that is often incorporated in parental touch, but may be important by itself, is restraint of movement. Parents typically restrain their child's movements by encumbering their arms when they are about to receive an immunization. However, newborn infants whose heels are lanced while they are separated from their parents are often turned on their backs and left to kick freely, thereby increasing proprioceptive and tactual input and heightening the infant's arousal. When a sympathetic adult inhibits the infant's writhing movements, the amount of proprioceptive feedback from gross motor movement declines. This soothing strategy, which is a major component of swaddling, may enhance the effectiveness of other soothing methods used for infants in pain.

Because young infants are exposed to painful medical procedures so frequently, systematic research on infant pain and pain reduction seems to be a very high priority.

In sum, there is a small but growing body of literature attesting to the potential effectiveness of behavioral interventions for the relief of pain-elicited distress in neonates and young infants. To date, studies have principally been descriptive, focusing on whether infants do or do not respond to a particular soothing intervention. Research has not yet addressed a number of important issues, such as how to maximize the effectiveness of interventions, or how to identify the processes that underlie the success of an intervention, or how to account for developmental changes in effectiveness of soothers. In light of the importance of soothability for infant temperament (Rothbart, 1981), it is especially striking that there have been few studies of individual differences in reactivity to different soothing methods. Because young infants are exposed to painful medical procedures so frequently, systematic research on infant pain and pain reduction seems to be a very high priority.

Parental response to infant pain

So far, we have discussed the issues of infant pain and soothing from the perspective of the infant. However, the infant is embedded in a network of social systems that just as effectively influence his or her behavior as does any single stressor or soothing intervention. The two systems we will now focus on concern the parents, and the health professional. Although research on the impact of both of these systems on the infant's pain and stress is just beginning, it is nevertheless clear that parental attitudes and behaviors, and the manner of health care delivery, can have important direct and indirect impact on the infant's stress and coping with pain.

Parental attitudes and behaviors, and the manner of health care delivery, can have important direct and indirect impact on the infant's stress and coping with pain.

Parents have a major role in helping their children cope with pain in infancy and childhood. It is a difficult role, with many facets. Parents must be able to identify pain, seek assistance when necessary, provide medication, and help the child cope with unrelieved pain. It is distressing to note that research on the role of parents in relieving infant pain is even scarcer than the literature on soothing methods just described. As a result, there are few findings to report, though there are many important issues to identify for future research.

Because there can be no intervention for a problem if the problem is not noticed in the first place, an important issue to address is helping the parent to identify pain in the infant. This is not an easy task: the parent must learn to distinguish the infant's cry signal and to differentiate it from hunger or boredom. Pain cries initiated by intense states, such as those following pin pricks or injections, are readily differentiated, but it is difficult for parents to recognize the pervasive states of pain that have slow onset. These include abdominal and teething pain. Future research needs to address this issues by carefully describing the infant's expression of slow-onset pain states, and by investigating the conditions associated with low intensity pain reactions in infancy.

Once parents have identified that an infant is in a state of pain, their ability to help the infant cope with it is influenced by the parents' interpretation of what is appropriate for the baby to experience, by their knowledge of what strategies are helpful to the child, and by their own reactions to the infant's distress. A parent's response to infant pain has two components: 1) the direct soothing provided by the parent, and 2) the emotional style with which the soothing is provided.

Infants quickly tune into the contingent manner in which the parent responds to the infant's states. Indeed, Lamb (1981) has argued that the infant's noticing of such contingent reactions forms the basis for the child's developing a sense of trust or a feeling of security with the attachment figure. The parent's success or failure, then, in relieving infant pain eventually may have long-term consequences for the quality of attachment an infant shows to significant others.

Parents need to learn more about the effectiveness of different soothing techniques at different ages as well as the general principles for comforting infants in pain.

In addition to whether the parent uses a method successful in relieving the infant's distress, the emotional style by which the parent reacts to the infant may be very important in affecting the infant's emotional state and arousal level. When an infant undergoes an unfamiliar stressful procedure, the parent's emotional signals are often critical determinants of how the infant will respond. This phenomenon is called *social referencing*, and is one of the most pervasive means by which an infant's emotions become socialized, i.e., how an infant "catches" an emotion from another person. A calm but sympathetic (or emphatic) response from parents may facilitate the infant's coping, or at least reduce the infant's level of arousal, whereas a distressed or anguished reaction by the parent may heighten the infant's distress. The parent's response to the infant's stress thus may have major direct and indirect consequences for the infant's later development.

Some parents have inappropriate expectations about how their child should cope with pain. It is not uncommon to see this in well-child clinics or pediatricians' offices when parents admonish young children not to cry before they are given injections by saying, "You're a big boy. Don't cry. It won't hurt." It may be useful to tell parents that provision of information to their child may help to buffer the child from the stress of inoculations or other painful medical procedures; that ridicule and shame of the child for crying in response to pain may be inadvisable and result in the parent removing himself or herself from the role of potential buffer for their child's pain. An alternative strategy can be to encourage parents verbally to anticipate how their child will react, and to plan for supportive measures before painful procedures are initiated. Simply acknowledging the child's pain is the first step in changing the emotional tenor created by the parent's anger.

Specific soothing strategies used by parents vary with the age of the child. Mothers of infants older than one year of age tend to use more verbal and indirect soothing techniques, whereas mothers of infants younger than one year tended to use more physical soothing interventions (Craig, McMahon, Morison, & Zaskow, 1984). Parents need to learn more about the effectiveness of different soothing techniques at different ages as well as the general principles for comforting infants in pain. Information on age-appropriate and context-appropriate means of reducing infant stress has not generally been incorporated into parent education programs.

The role of the health care professional in facilitating coping with pain

There are at least four ways in which health care providers can affect the infant's levels of stress in response to pain besides the use of pain reducing techniques such as those described before.

First of all, **health professionals can model the caring process for parents.** After conducting any procedure that is stressful to the infant, a practitioner can rock, pick up, pacify or take other appropriate steps to reduce the discomfort to the infant. By doing so, parents observing the provider's behavior are encouraged not to disregard their child's signals of discomfort. Such modeling is especially important in the newborn period, when parents are establishing their caregiving patterns, and may be particularly receptive to suggestions on comforting.

Secondly, **health professionals can use painful medical procedures as an opportunity to help parents learn to cope with infant pain.** By encouraging parents to soothe their infants after a painful procedure, health professionals create an opportunity to observe parental comforting strategies and to reinforce empathic parental responses. Parents can be encouraged by such comments as, "My, how quickly the baby responds to your touch." If parents are not successful at soothing, they may welcome a discussion of how long it often takes an infant to quiet down after experiencing pain, or they may be open to suggestions about the effectiveness of different soothing strategies. For example, a nurse may advise the parent to hold the infant close after a stressful procedure, or she may encourage the parent to provide an opportunity for the baby to suck, either by nursing or by use of a pacifier. Because premature interruption of soothing interventions may lead to frustration for both the parent and the infant, health care providers may need to become sensitive to how long the parent permits a soothing intervention to work. Parents should also be reassured that some interventions become more effective as the parent and infant gain experience with them. In sum, stressful medical and nursing procedures can, with the help of sensitive health care providers, become settings whereby parents can gain a sense of personal efficacy.

There is another side to the opportunity to help parents learn to cope with infant stress. Observation of parent interaction after a stressful procedure provides the health professional a window on one of the most challenging aspects of parental role, the ability to soothe a crying infant. When parents ignore the opportunity to comfort their child, health professionals may need to intervene to foster parental empathy.

The third way in which health care providers can reduce infant reaction to pain is by **understanding and implementing those steps they can take to help minimize the inpact of stressful procedures.** Health care professionals can use **timing, social interaction** to reduce the impact of environmental stimuli which heighten the infant's level of arousal. By doing so, health professionals may possibly *decrease* the likelihood that a baby will have a more intense and prolonged reaction to pain. For instance, painful procedures can be scheduled to avoid times of peak infant arousal, such as when the infant is hungry. Or arousal can be reduced by having someone available to hold and stroke the infant or to provide him/her with a pacifier to suck during the medical intervention. Unnecessary sources of arousal such as background noise can be reduced as well. Care can also be taken in scheduling blood drawings so that a blood sample for a P.K.U. test, for instance, can be delayed until a blood sample for bilirubin is collected at the same time. Self-soothing can be fostered by positioning the infant in a prone setting during heelsticks, in order to make it easier for the infant to suck his/her fingers and to inhibit erratic movements. The use of skin coolant sprayed on the injection site immediately prior to the injection is another method for minimizing the distress of painful procedures (Eland, 1981).

Routine procedures should also be studied to determine if alterations might minimize the duration of painful stimulation. Small changes in a procedure can sometimes significantly reduce its duration, and thus the length of time the infant is exposed to a stressor. For example, Harpin & Rutter (1983) reported that the use of a mechanical spring loaded cartridge lancet reduced the infant's arousal, and decreased the need for a second stick. Alternatively, the use of heel warmers and the practice of a double heelstick at the beginning of the procedure can shorten the duration of blood collection procedure by hastening blood flow. Less routine procedures should also be investigated to determine how to minimize the duration of stress.

Although long-term consequences of pain experiences in infancy have not yet been demonstrated, pain may, in fact, have damaging effects, as was mentioned above (Beyer & Byers, 1985). The repeated painful insults experienced by preterm infants in neonatal intensive care units may predispose these infants to increased irritability, thus magnifying the challenges for parents who are already overloaded with the demands of providing home care to low birth weight infants. Health care professionals should consider the possibility that not all heelsticks are essential to the infant's welfare. For example, nursing assessment of infant behavior and response to feeding may be just as accurate in predicting resolution of breast milk jaundice as repeated heelsticks for bilirubin level.

Finally, **physicians and nurses can help parents cope with their child's pain by encouraging the parents to discuss their own fears and reactions to pain.** Many parents are uncomfortable being present when their child has to undergo a painful procedure. Acknowledging that the pain experienced by the infant and the baby's piercing cries create unpleasant sensations in the listener encourages parents to discuss their own reaction to crying and pain. Without this opportunity for discussion, the parent may convey nonverbally to the infant his or her own reactions to pain, The parent's guilt and discomfort may inhibit empathic responses. Enabling parents to cope with their own reactions to pain is an important first step in helping parents meet their children's needs.

Conclusion

A new environment for infant care is now emerging that is becoming increasingly responsive to the impact of medical and nursing interventions on infant state. Recent studies of infants' facial, physiological, and behavioral responses to stressful procedures, and of caregiver interventions to reduce stress are helping to humanize our care of infants. However, much systematic research on infant pain and soothing needs to be done in order to provide practical guidelines to parents and health care providers.

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Managing Pain in Young Children: A Pediatrician's Perspective

by
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With the advent of new pain assessment tools, a better understanding of analgesics and anesthetics, and the development of more comprehensive clinical approaches to children and parents, health care providers are now in a position to prevent and relieve pain more completely than ever before.

Assessment of pain in children

There is now sufficient research experience with assessment scales that measure pain/discomfort in infants and children to warrant their use in routine medical care. These scales are simple to use and provide discomfort scores which have been shown to be reliable and useful guides to pain therapy.

The Children's Hospital of Eastern Ontario Pain Scale (Figure 1) has been used successfully with children up to age seven following minor surgical procedures such as circumcision (McGrath, et al., 1985). Scores range from 5 (low pain, high comfort) to 13 (high pain, low comfort). Pain scores respond to analgesic or anesthetic medication in a predictable manner. This objective approach to behavioral observation permits a high degree of reliability between observers. A single measurement can be completed in less than 60 seconds.

Children's Hospital of Eastern Ontario Pain Scale

		SCORE
CRY	—No cry—1; moaning, whining or whimpering—2; crying or sobbing—2; screaming or shrieking—3	
FACE	—Smiling—0; neutral—1; grimace, frown or concern—2	
VOCAL	—No complaints—1; non-pain complaings—1; pain complaints—2; pain and non-pain complaints—2	
TRUNK	—Fully relaxed-1; upright, restrained or not relaxed—2	
HANDS	—Relaxed, not moving to wound or injury-1; not relaxed or moving toward wound or injury—2	
LEGS	—Relaxed or not moving—1; not relaxed or restrained—2	
	TOTAL SCORE	

Figure 1: *From McGrath, et al 1985*

An assessment tool which may be more applicable to younger infants was recently published by Attia et al (1987) (Figure 2). The inclusion of sucking behavior, consolability, excitability and sociability permits greater attention to more subtle cues of discomfort. This scale has also been shown to be sensitive to medical therapy in a predictable manner. Scores range from 0 (maximum discomfort) to 20 (maximum comfort). Successful use has been reported in infants less than 1 year of age undergoing various minor surgical procedures (hernia repair, circumcision, etc.) (Howell and Rubin, work in progress).

Measurement of Postoperative Pain in Infants

	SCORE			
	0	1	2	subtotal
1. Sleep during preceding hour	none	short naps 5-10 min.	longer naps 10+ min.	
2. Facial expression of pain	marked, constant	less marked, intermittent	calm, relaxed	
3. Quality of cry	screaming, painful, high pitched	modulated, can be distracted	no cry	
4. Spontaneous motor activity	thrashing, incessant agitation	moderate agitation	normal	
5. Excitability and responsiveness to stimulation	tremulus, clonic movements, Moro reflexes spontaneously	excessive reactivity to any stimulation	quiet	
6. Flexion of fingers and toes	pronounced, marked and constant	less marked, intermittent	absent	
7. Sucking	absent or disorganized	intermittent, (3 or 4) stops with crying	strong, rhythmic, pacifies	
8. Overall tone	strong hypertonicity	moderate hypertonicity	normal	
9. Consolability	none after 2 minutes	quiet after 1 min. of effort	quiet within 1 minute	
10. Sociability (eye contact) in response to voice, smile, face	absent	difficult to obtain	easy and prolonged	

TOTAL SCORE ________

Figure 2: *From Attia, J. et al 1987*

Subjective scales for evaluating discomfort in infants seem to correlate moderately well with objective observation tools (Attia, 1987). When an observer asks himself "How much discomfort do I feel the child is currently experiencing?", and answers on a scale from 0 (no discomfort) to 10 (maximum discomfort possible), he is attending to the child's experience, rather than dismissing it.

It is important for health care providers to become comfortable with the reliability of tools for assessing pain in children and to use them regularly. In doing so, practitioners are more likely to detect pain and to provide more aggressive pain management for the medical procedures children undergo.

Pain therapeutics

The medical management of pain in infants and children is not complicated. Infants can receive almost any pain medication given to older children and adults. Acetaminophen, codeine, fentanyl, meperidine, morphine, bupivicaine, lidocaine, dibucaine, and benzocaine are all analgesics or anesthetics for which infant doses can be prepared and administered. They are variously available in topical, oral, rectal, and/or injectable form. They can be used as premedication before procedures or to treat pain afterward. Adverse effects are no different than in adults and include sedation, upset stomach, and/or allergic-type reactions. Should excessive sedation occur with the use of a narcotic analgesic, an antidote is available which quickly counteracts this effect. Health care providers should become familiar with these medications and develop comfort with their use in infants and young children. Premedication of some type, prior to painful minor procedures, should arguably be standard practice rather than the exception. Information about doses, side effects, and management of adverse reactions to narcotic and non-narcotic analgesic indications can readily be found in common pediatrics reference texts and manuals. Similar information about anesthetic medications is less readily available but can be found in texts on pediatrics anesthesiology. Recent publications which may be found useful are in the bibliography at the end of this article.

Clinical approaches to young children in pain, and their parents.

Health care providers who serve infants and toddlers must be able to empathize not only with the child but with the parents as well. Specific clinical approaches are suggested by Rosemary Campos (this issue). The aspects of behavior we seek to model are important within all human relationships—compassion, protection and respect. Health professionals can model compassionate behavior by communciating empathy and sympathy in words, by helping parents to console a child in pain, and by using or advising medical therapy where indicated.

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When a Child Is Inconsolable: Staying Near

by
Lois Barclay Murphy

I am speaking of an experience that does not necessarily dominate a child's life, but that needs special consideration. Babies and children have many different cries—whining or screaming in hunger, fussing in boredom, raging in a temper tantrum when frustrated, squealing in pain, or shrieking in terror. We can usually help the baby in these circumstances: We can provide food for the hungry child; we can change the position of the baby who is bored—lifting the infant to a shoulder for a new view of the world, or taking the baby to a different room to see something new. We can remove the cause of the pain or offer comfort with soothing massage, patting or rocking or if the child is old enough to understand, "Mommy will kiss it and make it well" that ritual can help. (We know now that endorphins in the nervous system actually act like morphine and can be stimulated by loving attention.) We can reassure the frightened baby by holding him or her close and talking in quiet tones.

But there is another cry that is hard for us to understand, and often there seems to be no way to help—a cry of woe, sobbing inconsolably, seemingly flooded with grief. There is nothing demanding, or irritable, or angry in this cry. Years ago I felt helpless when I saw a little boy of two sobbing his heart out, leaning with his face against a screen door of his house where I was visiting. I tried to console him but he pushed me away as if nothing I could do could help. Sometimes a child in this despair seeks solitude behind a curtain or a tree; sometimes by lying face down on the floor. In our nursery school years ago, a little boy hid in the empty fireplace, unreachable, broken-hearted, overwhelmed on his first day away from his mother—two years old, not understanding that she would return.

That first little boy is a man now, gifted, sensitive, perceptive. When I recalled that incident when he sobbed, unreachable, and said that I felt that the inconsolable child needs to be understood, he agreed and wrote me a letter about his reflections:*

> "The inconsolable state of grief, or what feels like an intolerable level of loss or disappointment, is a very important point where the child begins to deal with our most fundamental relationship—call it existential despair, or call it, 'damn it, don't you understand, *this* tradegy is unfixable!'. If a precious toy is lost, or a trust betrayed, or some such tragedy, it may evoke the feeling that this is not something I will be negotiated out of. I won't be seduced by offers of warmth or food or entertainment. This is non-negotiable. (Is this what is known as integrity?)
>
> "Somehow it feels as though what we ask for in that inconsolable state is the acknowledgement that, 'yes, it is unfixable. No, nothing could be worse than this.'
>
> "What prevents the so-called adult from being able to truly BE with the inconsolable child? I mean the child seems to know exactly what to do and how to do it. It wails and moans with great stamina. What about the adult, though? Do adults experience the exact same level of inconsolability? What has really changed in 'growing up'? What has changed is that the adult has acquired a learned ability to deny, and negotiate the unnegotiable tragedy. We are considered grown up when we no longer behave childishly, but the really vital question is whether we have faced the unfixable tragedy of life. Have we faced it, or have we negotiated it into a managed state? Doesn't the child show us exactly where we stopped in growing up ourselves? The impulse is to calm the child, to make things better. But the scream comes back, 'Don't even try to calm me down!' whether in words or equivalent. Why is this so unnerving? Doesn't it evoke all the fear, resentment, frustration, which hasn't really changed at all since our own childhood? And isn't the impulse to get the child calmed down, by any means possible, an impulse to stifle this Pandora's box? It's an enormous challenge to really be with the child in its inconsolable state.
>
> "That child is ourself. We want love, which is always going to turn out to be less dependable than the infinite we hoped for. We want psychological security and it will never be enough. We want physical security. We want to continue as me forever. Our wants, and *perceived* needs come up bang against the wall of aloneness which wanting and hoping and grasping creates. Then, can we be with the sadness this evokes? Can we feel it, the impulse to run away from it, the absoluteness of it, the non-negotiable nature of our predicament as a vulnerable, scared human being? Perhaps if we truly perceive the fact that there is *nothing* I can do, then the child/adult may for the first time be free from an enormous burden of managing the unmanageable.
>
> "The notion that I, as an 'adult', should know what to do with the inconsolable child is a myth which can only add pressure and fear when I realize I *don't* know what to do. As soon as there is a formula of how to deal with inconsolability, then I am the adult raising the child. But in truth the child and I are both trying to grow up together. Why *should* I know what to do? And he or she has something to remind me of here.
>
> "You say to stay near. I agree. What ideas, fears and so on separate us from the child? Whether it's the child or ourselves, it's the same pain, isn't it? Whether we are 2 years old, 32 years old, 92 years old, we face the same fear of the unknown, and the same unnegotiable grief when someone or something we love isn't available. Can we openly *not know* the answer?
>
> "Doesn't such a state of openness communicate itself?—to a child, to a dog or a cat, or to the people we live with?"

I was grateful for my young friend's suggestions that it is not just the infant or child who has inconsolable moments. I remembered exactly that kind of inconsolable crying when at the age of thirteen the time came to leave a happy fortnight at camp when I would have to return to a very difficult school situation. I wanted camp to go on forever, and it could not. Again when much later three dear friends died of a heart attack and cancer one after the other—they could not be replaced. The tragedies "could not be fixed" as the letter said.

With the baby or young child, the *feeling* that it can't be fixed, that the loss is unbearable, yields in time to discrimination between those losses that can't be fixed and those that can. But at the moment of inconsolability all we can do is to stay near, so that the child knows that we care, and when the crying is finished, we can be together.

---

*This letter from Kevin Frank

Point of View:

Conceptualizing Screening Models for Developmentally Disabled and High Risk Children and Their Families

by
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Interest has increased appreciably in recent months for the prompt and accurate identification of infants and young children with developmental disabilities as well as those who are at substantial risk for school failure. The impetus for this amplified concern is both empirical and legislative in nature. Studies examining the effects of early intervention services for handicapped infants and young children report encouraging findings in terms of both child and family centered outcomes (Shonkoff and Hauser-Cram, 1987; Guralnick and Bennett, 1987). Moreover, recent cost/benefit investigations indicate that for every $1.00 invested in early intervention services, there is a $3.00 reduction in long term, public special education costs (Berrueter-Clement, 1984; Garland et al., 1981).

In addition to these powerful program effects, the recent enactment of P.L. 99-457 carries with it the specific charge that all states should develop a plan which will address the special education and related service needs of all handicapped children from birth to five years of age, with special emphasis on children who are often *not identified* and children *who are not now served*. Thus, an acute need exists for valid early detection models. While the intent and purpose of these mandates are clear, the precise implementation strategies and associated policy guidelines to insure the appropriate translation of this mandate are far less evident.

Research conducted for nearly three decades into the isolation of factors predictive of subsequent learning and/or behavioral competency has verified the complexity of the problem. In predicting intellectual functioning, for example, studies using single predictor variables such as anoxia (Corah et al., 1965), prematurity (Wiener, 1962), and neurological status (Parmelee and Michaelis, 1971) have shown little or no correlation with subsequent measures of intelligence.

Other studies that have examined isolated factors as well as the interaction of multiple indices report results only marginally more encouraging (Chamberlin, 1977; Levine et al., 1977; Drorbaugh, Moor, and Warram, 1975; Denhoff, Hainsworth and Hainsworth, 1972). In studies that have attempted to determine the power of the critical birth variable perinatal anoxia, alone and together with other variables (e.g., socio-economic status, sex and birth weight) to predict subsequent intelligence, Broman (1979) reported that "the prediction of cognitive outcome using signs of perinatal anoxia alone or in combination with other predictors resulted in an estimate of the magnitude of the relationship which was very small in infancy and even smaller in childhood" (p.51). Similarly, Sigman and Parmelee (1979) found that even using a wide range of risk variables (e.g., obstetrical complications, newborn neurological examination, visual attention, Gesell Development Scales, etc.), the categorization of infants based on the risk-score system had limited predictive value with respect to later measurement of mental, motor, and language indices. In short, longitudinal developmental predictions based upon constitutional factors alone are weak and inaccurate.

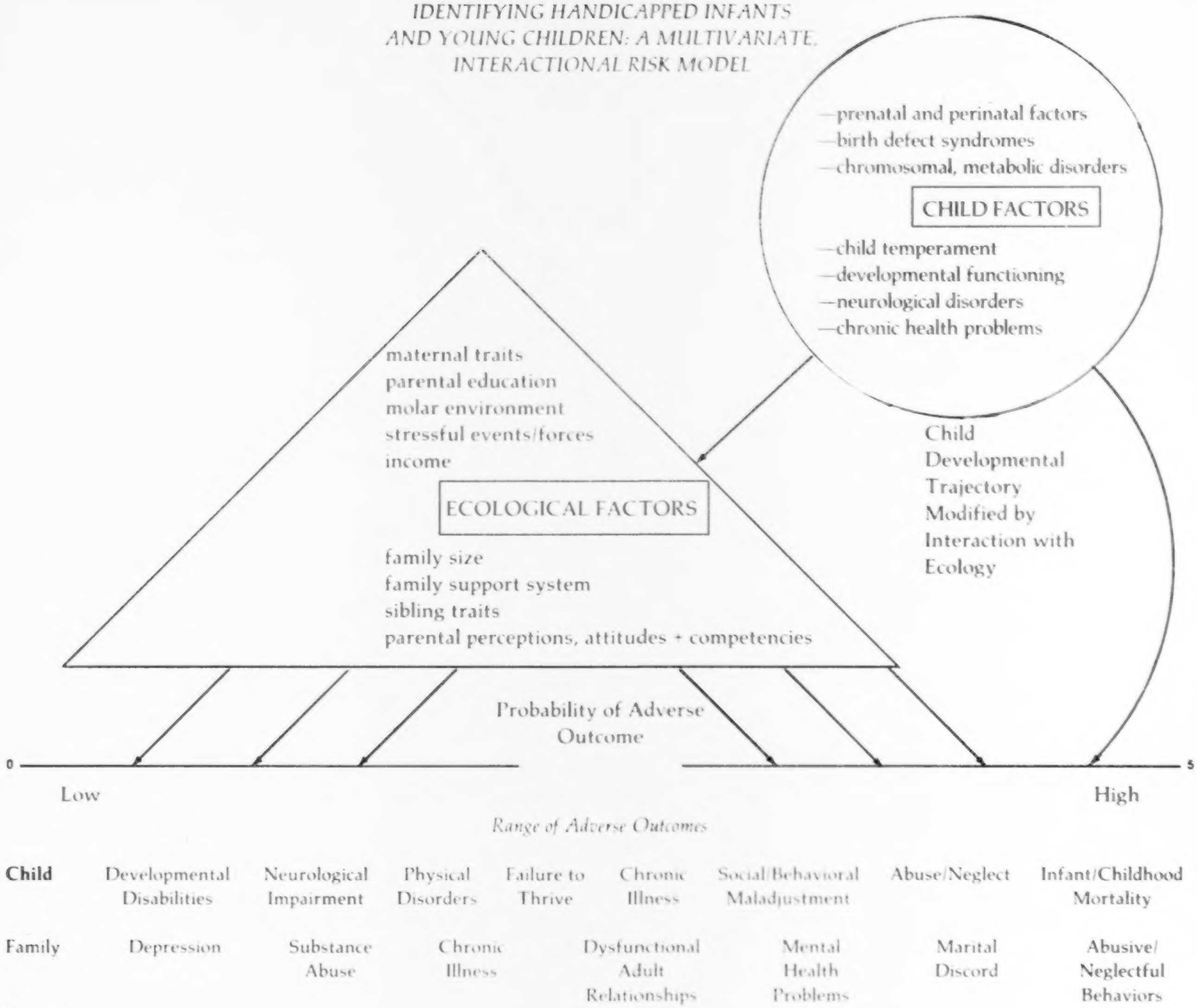
> *Existing screening systems continue to be plagued with errors which can either deny services to needy families or expand scarce resources on children who do not need intervention. This article describes the theoretical underpinnings of a screening system based on a multivariate interactional risk model. Since programs designed to respond to a wide range of adverse outcomes typically reside within different state agencies an interagency, family focused screening approach seems justified.*

Other prospective studies have indicated that developmental outcome from infancy onward is related significantly to environmental hazards and to a "continuum of caretaking casualty" rather than to prenatal and perinatal difficulties (Sameroff and Chandler, 1975; Werner et al., 1977). Recent studies which have compared the predictive power of child centered measures with ecological factors (Mitchell et al., 1985; Siegel, 1985; Bee et at., 1982) have suggested that: (1) isolated measures of child performance, particularly prior to 24 months of age, are of little utility in predicting subsequent behavior; and (2) environmental factors (Nichols and Chen, 1981) and parent/child interaction (Cohen and Beckwith, 1979) have greater power in predicting the occurrence of cognitive, language, and motor deficiencies in school-aged children. More importantly, while the ongoing interaction between child vulnerabilities and ecological quality are critical elements of any screening model, the precise combination of variables and their respective weights over chronological age continues to elude specificity. As a result, existing screening systems continue to be plaqued with errors (both false positives and negatives) which can either deny services to needy families or expend already scarce resources on children, who, in fact, do not require intervention.

In conceptualizing screening and assessment models for infants and toddlers, several studies (Kochanek, Kabacoff and Lipsitt, 1987; Broman, Bien, and Shaughnessy, 1985) have underscored that critical role of ecological factors as a determinant of child outcome. Early detection models, particularly for children less than 12 months of age, which rely exclusively upon adverse factors manifested in infančy and early childhood, are highly likely to misclassify substantial numbers of eventually handicapped children as non-handicapped (Mitchell et al., 1985).

Figure 1

IDENTIFYING HANDICAPPED INFANTS AND YOUNG CHILDREN: A MULTIVARIATE, INTERACTIONAL RISK MODEL


—prenatal and perinatal factors
—birth defect syndromes
—chromosomal, metabolic disorders
CHILD FACTORS
—child temperament
—developmental functioning
—neurological disorders
—chronic health problems
maternal traits
parental education
molar environment
stressful events/forces
income
ECOLOGICAL FACTORS
family size
family support system
sibling traits
parental perceptions, attitudes + competencies
Child Developmental Trajectory Modified by Interaction with Ecology
Probability of Adverse Outcome
0
5
Low
High
Range of Adverse Outcomes
Child
Developmental Disabilities
Neurological Impairment
Physical Disorders
Failure to Thrive
Chronic Illness
Social/Behavioral Maladjustment
Abuse/Neglect
Infant/Childhood Mortality
Family
Depression
Substance Abuse
Chronic Illness
Dysfunctional Adult Relationships
Mental Health Problems
Marital Discord
Abusive/Neglectful Behaviors

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Beyond the obvious need for a multiple risk interactional model, equally important is the requirement to move beyond relatively static "macroscopic" factors (e.g., maternal education, socio-economic status) to more focused "microscopic" risk measures dealing with psychologic, familial, and interactional variables within the family unit. Several recent studies are illuminating in this regard. For example, Sameroff, Seifer, Barocas, Zaz and Greenspan (1987) report findings from the Rochester Longitudinal Study which not only reinforce the immense power of multiple, cumulative risk on cognitive development, but more importantly, present specific measures which prove statistically influential in determining child outcome, such as maternal anxiety and mental health, mother-child interaction, family support, and stressful life events. Results in this study indicated that as the number of risk factors increased, intellectual performance decreased, with the difference between the lowest and highest groups being approximately 30 IQ points. Of greatest interest is that *no* child centered information was entered into the multiple risk analyses, yet the two groups differed by approximately two standard deviations.

Similarly, other researchers (Dunst et al., 1987; Barnard and Bee, 1985; Mitchell et al., 1985) have developed measures of family well being, parent attitude and competence, and intra and extrafamilial support systems which facilitate the development of alternative, multiple risk decision making models. Viewed collectively, Figure 1 portrays the theoretical underpinnings of such a screening system and also suggests that these same child and ecological factors are precursors to a wide range of adverse outcomes including developmental disabilities (Susser et al., 1985), infant and childhood mortality (Wise et al., 1988), child abuse and neglect (Meier, 1985; Garbarino, 1986), and psychiatric hospitalization (Pfeffer et al., 1985). Given the robust empirical foundation of such a risk model, and also that programs designed to respond to these various afflictions typically reside within different state agencies, the justification for an interagency, family focused model seems indisputable.

As states begin to conceptualize screening models designed to identify high risk children and families, several significant implications of the above findings are noteworthy.

1. **Early detection and intervention efforts must broaden in definition and scope.** The degree of risk or the severity of potential developmental disability for infants cannot be accurately predicted by the occurrence of any one traumatic prenatal or neonatal event. Studies that have followed a medical model of disease, attempting to identify a linear relationship between cause and outcome, have produced disappointing results. In fact, evidence suggests that selecting children for programs based upon isolated factors (e.g., SES (Gallagher and Ramey, 1987)) provides no assurance that those most in need will be served.

2. **Screening models must include sources of data beyond that presented by the child alone.** Longitudinal studies report complex interactions between a child's physical, neurological, and developmental status and the environmental context within which a child is reared (Werner and Smith, 1982). Assessing newborn and early developmental status is of equivalent importance to caregiver response and adaptation to the developing child.

3. **Surveillance programs should be serial in their operation.** Because of the instability of findings reported in several studies (Levine et al., 1977), screening models must be periodic and multivariate in design, and reflect an ongoing *process* which discriminates between transient and permanent problems and takes into account child/environment transactions.

4. **Screening models must include ecological factors both at the *macroscopic* (e.g. maternal education) and *microscopic* (e.g., maternal/child interaction; family needs/resources/support systems) levels.** As such, designs which incorporate two sequential stages, differentiated by the type and specificity of information collected, appear to be preferable to models which are single events with binary outcomes (i.e., refer for diagnostic evaluation; exit from system).

Studies which have attempted to examine the outcomes of early intervention services are also illuminating with respect to crafting a serial, multivariate screening system. Carl J. Dunst and his colleagues have launched a creative, comprehensive programmatic research effort which has focused upon the role which social support plays in promoting adaptations to the rearing of special needs children. In brief, Dunst et al. (1987) postulate that social support has direct and indirect influences on parent well-being, family integrity, parent/child interactions, and child behavior and development. Dependent measures in these studies have included parental well-being and coping, family integrity and adaptations, parental styles of interaction, and child developmental competence. Studies have indicated that social support not only accounts for a significant amount of variance in the dependent measures, but also proves to be the most significant mediating variable, even when compared to parent and child characteristics and formal (i.e., professional) sources of support.

Additional studies exist (Trivette and Dunst, 1986) which provide further substantiation that health and well-being, time demands placed upon the parents by the child, family integration, and parent perceptions of child functioning were, in part, affected by the helpfulness of a family's informal social support network. Overall, these and other studies (Cohen and Syme, 1985; Crnic et al., 1986) have found that support plays a significant role in affecting parent, family, and child functioning, and adds to a growing body of evidence which suggests a family systems perspective to assessment and intervention.

In summary, four areas of family functioning appear to have demonstrated value and impact and are worthy of consideration in the design of a screening process (Kochanek et al., 1988); these respective areas include:

Family needs, resources, and strengths
Social support network
Significant life stressors
Characteristics of the caregiving environment

Screening models which attempt to accommodate the above areas of family functioning should reflect the following essential principles.

1. **That the primary goal of the screening process is to identify all children from birth to five with developmental anomalies *as well as* vulnerable, low resource families within which children are at a substantial risk for subsequent school failure.** The concept of limited resources is not restricted to tangible areas (e.g., income, housing, medical care, nutrition), but also includes maternal/primary caregiver characteristics such as parenting skills, social/emotional competence, ability to access and appropriately utilize community services, alternative modes of dealing with adversity, access to intrafamilial and extrafamilial support systems, and interpersonal and intrapersonal competence.

2. **That in order to minimize decision making error, the screening process should include two stages which reflect different degrees of specificity at each level.** To the maximum extent possible, the screening model should be incorporated into all existing programs/services (e.g., MCH neonatal screening, EPSDT, Preventive Pediatric Services). Moreover, the basis for a decision regarding need for additional diagnostic testing shall be made according to three sources of information: (a) child characteristics, (b) parental traits, and (c) maternal/child interaction.

3. **That due to significant variation in child developmental pathways as well as ongoing changes in family status, all children and families should be examined on multiple occasions between birth and three years of age.** Judgments regarding the need for

additional evaluation would be based upon evidence of jeopardy at individual time points as well as from determination of cumulative risk.

While the studies presented are enormously helpful in prompting the creation of more comprehensive screening models, it is critical to note that no reliable and valid process or decision making equation which incorporates child and family focused measures has yet been designed. Consequently, as such experimental models are developed, careful field trial periods are mandatory prior to widescale adoption. Significant evaluation questions which must be addressed in such pilot projects are as follows.

1. What differences exist in the population identified by the proposed screening model in contrast with that identified by existing referral pathways and casefinding techniques? What specific factors in the model account for these differences?

2. What contribution does each screening factor (i.e., child and family) make to key decisions such as screening, program eligibility, assessment, and IFSP development?

3. Does the significance of specific screening factors change over time, and if so, how can this dynamic quality be incorporated into a systematic screening process for children from birth to five and their families?

Adoption of family measures within early intervention programs carries with it the opportunity to view eligibility from a fresh and novel vantage point. While the development of risk responsive, coordinated, and comprehensivw IPSPs remains as the principal outcome of child and family assessment as reflected in P.L. 99-457, commitments to specific measures will invariably prompt a range of complex questions. Such issues include not only the population eligible for early intervention services, but also the manner in which this population is most appropriately served. Programs will need to develop appropriate and technically sound implementation plans such that the above representative questions may be answered.

The potential impact and benefits of models which reflect the above recommendations are both varied and far-reaching in nature. First of all, the development of a comprehensive identification system should result in major strides in eliminating the gaps among the social, educational and health systems and also reducing fragmentation among numerous administrative agencies. Moreover, the existence of a longitudinal, consistent plan should help policymakers achieve evolutionary, systematic, and graduated improvements in the screening process, rather than episodic, reactionary and short-term changes.

Secondly, such models would encompass several unique and novel aspects including: (1) a transagency identification model, with specific focus on both health care and educational systems; and (2) a screening and program eligibility model solidly grounded in actuarial and epidemiologic statistics.

P.L. 99-457 creates a rich opportunity for states not only to provide quality services to developmentally disabled children, but also to articulate and implement more comprehensive and aggressive efforts devoted to prevention. To the extent that state governments are interested in both challenges, the above recommendations are intended to provide an important context within which thoughtful and creative solutions may be generated.

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National Center Notes

by Eleanor S. Szanton

While the terms "prevention" and "early intervention" are widely used in connection with initiatives designed to support the healthy development of infants, toddlers and their families, these words still seem symptomatic of the ambivalence with which our society has typically viewed services for children from birth to three. We hear for example, about prevention of low birth weight and infant mortality through better prenatal care. Pre-school for four year-olds is described as an effort to prevent school failure. But few "prevention" efforts are aimed at children and families in the critical first three years of life. There are programs of early "intervention", to be sure, but for the most part these are available only to children with documented disabilities or developmental delay or to children and families in which abuse has occurred.

NANCY P. ALEXANDER

Early *facilitation* is surely a more appropriate word to describe the range of integrated services that are needed to support the development of all children from birth to three and their families. Every family with an infant or toddler needs health care, child care options, and consultation around development and childrearing to a greater or lesser degree. Families facing multiple stresses need supports that are comprehensive, coordinated, and continuing, as Lisbeth B. Schorr has documented so well in her book *Within Our Reach: Breaking the Cycle of Disadvantage* (New York: Anchor Press, Doubleday, 1988).

Several pieces of some recent federal legislation create new opportunities for facilitating healthy development in the earliest years of life:

- **Mandatory expansion of Medicaid eligibility** for pregnant women and infant under one year with family incomes below the federal poverty level, and options to extend that coverage to pregnant women and young children with incomes up to 185% of the poverty level provide new opportunities for the expansion of EPSDT, Medicaid's program of Early and Periodic Screening, Diagnosis and Treatment. EPSDT, a required service under each state's Medicaid program, is designed to identify children's medical, dental and developmental needs and to provide prompt diagnosis and treatment of disclosed conditions. Much can be done by states to improve EPSDT's outreach to eligible children, the content of care, and referral systems. Increasing the supply of appropriate providers and expanding benefits packages are also important challenges.

- **The Family Support Act of 1988** (welfare reform) gives states an opportunity to plan comprehensively for the well-being of our most economically disadvantaged young children and families, particularly adolescent parents and their infants. In order for the law genuinely to facilitate the escape of the next generation from poverty, attention must be paid to the quality of child care provided, to the extent and quality of health care, and to work and training opportunities that foster self-esteem and independence.

- **The Comprehensive Child Development Centers Act,** signed into Law in 1988 as part of the Elementary and Secondary Education Act, will support 10-20 programs that offer "intensive, comprehensive, integrated and continuous supportive services for infants and young children from low income families" who "because of environmental, health, or other factors need intensive and comprehensive supportive services to enhance their development." Services to children may include health services, child care, early intervention for children with or at-risk of developmental delays, and nutritional services. Services designed "to better enable parents and other family-members to contribute to their child's healthy development" may include prenatal care, parent education, referral to education and employment services, and assistance in securing adequate income support, health care, nutritional assistance and housing.

- **P.L. 99-457, the Education for the Handicapped Act Amendments of 1986,** has given states unprecedented opportunities to develop comprehensive, fully integrated services for children from birth who may be in danger of compromised development.

As a result of these and their own initiatives, some states are indeed beginning to think about health, education and social services as part of an overall *facilitative* approach; and there is excitement in the air about the possible positive cumulative effect of these concurrent initiatives for infants, toddlers and their families. Still missing, unfortunately, are federal legislation to improve the supply of adequate and affordable child care for infants and toddlers and federally mandated job-protected family and medical leave.

A New Year, a new Administration and a new Congress will soon begin. May they hear this message of *facilitation* from some states and reinforce it in others!

New NCCIP Publications on Infant Day Care

Infants, Families and Child Care: Toward a Research Agenda is a 16-page pamphlet designed to assist the general reader who may be baffled by reports of apparently conflicting research findings in the field of day care for infants and toddlers. The pamphlet describes areas of consensus reached by 17 leading child care researchers who were brought together by NCCIP at a "summit meeting" in the fall of 1987.

To help the general reader understand the vocabulary, assumptions and outstanding questions involved in infant day care research, *Infants, Families and Child Care* includes a 5-page discussion of infant day care research concepts in non-technical language. This section discusses descriptive studies that are currently underway, the "ecological" approach to infant day care research, research design and measurements, predicting long-term out come, and interpretation of data.

Who Will Mind The Babies? Second Edition is an updating of NCCIP's 1984 public policy paper of the same title. The 22-page booklet provides a framework for thinking about the many policy issues involved in developing assurance of adequate child care opportunities for infants and toddlers under three. Topics addressed include: the special needs of infants and toddlers; public policies which support parents who remain at home to care for infants and toddlers; professional recognition and training for caregivers; financing adequate child care; and policy-relevant research issues concerning child care for very young children.

Infants, Families and Child Care is available from NCCIP for $1.50 per copy and *Who Will Mind The Babies?* for $2.00 per copy. Prices include postage and handling.

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Make check payable and mail to National Center for Clinical Infant Programs, 733 15th Street, N.W., Suite 912, Washington, D.C. 20005

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Publications

Critical Issues in the Early Development of Premature Infants (1988)—Sibylle K. Escalona (Yale University Press, 92A Yale Station, New Haven, CT 06520) $35.00.

This volume presents a detailed description of the development and life experience of 106 low-birthweight infants, from the time they were patients in the neonatal intensive care unit of an urban teaching hospital in 1975/76 until they reached the age of 40 months. The varied socioeconomic and ethnic backgrounds of participating families made possible an examination of developmental patterns that emerge under widely different conditions of childrearing. The two primary measures of developmental progress used by the study were cognitive test scores and assessment of impulse control. Findings are reported separately from the "intact" group of children (who showed no neuropathology and no severe behavior difficulty) and for two "deviant" groups (those who had conspicuous behavior difficulties and those who had suffered neurological impairment).

Although the absence of a control group (lamented by the author) made it impossible to identify the developmental consequences of prematurity itself, the study did yield the following "impressions and hypotheses": 1) that low birthweight infants are less resilient to stress than full-term infants; 2) that emotional and behavioral difficulties arise more frequently among preterms, especially in the early preschool years; 3) that "soft" neurologic signs during the first two years often herald later learning difficulties or diagnosable neuropathology; and 4) that environmental circumstances have a great deal to do with the remediation or exacerbation of the developmental consequences of CNS abnormalities or deficits.

The volume includes detailed vignettes describing the life experiences of eleven children, representing both the "intact" and "deviant" groups and a range of growth-supporting or risky environments.

Mothers Alone: Strategies for a Time of Change (1988)—Sheila B. Kamerman and Alfred J. Kahn (Auburn House Publishing Company, 14 Dedham Street, Dover, Massachusetts 02030-0658) $26.95.

The authors of this volume identify four main policy choices that might address the circumstances of mother-alone families: 1) **an anti-poverty strategy** that would provide a guaranteed minimum income for all poor families; 2) **a categorical single-mother strategy** that would permit single mothers to remain at home until their children are school age; 3) **a family policy strategy with a special focus on young children** that would provide modest cash benefits to all families with children and further supplements for very young children; or 4) **a family policy strategy of integrating work and family life** that would facilitate participation in the labor force and provide both the economic benefits and the social supports which are essential if parents of young children are to work.

After examining the diversity of one-parent families, past U.S. policies, and the experience of other industrialized countries, Kamerman and Kahn propose an income package for single-parent families that includes earnings, child support and government transfers to supplement other income. They recommend that work program requirements for single mothers be deferred until the child is at least one year old but believe that to delay until the child is age 3 "may create overwhelming obstacles to the eventual employability of many of the young mothers." As in their past writings, the authors argue strongly for job-protected and paid parental leave and improved infant/toddler child care. They also recognize that inadequate income is not the only problem facing mothers alone: lack of time and social support are also serious issues.

Holes in the Safety Nets: Poverty Programs and Policies in the States, National Overview (1988)—Isaac Shapiro and Robert Greenstein (Center on Budget and Policy Priorities, 236 Massachusetts Avenue, N.E., Suite 305, Washington, D.C. 20002) $8.00 for National Overview, $3.50 each for individual state reports.

Although one often hears of "the safety net" protecting the poor, the authors of this report point out that in reality there are 51 safety nets, of vastly different quality, in the United States. The Center on Budget and Policy Priorities has published individual reports on benefit and income-related programs (as distinguished from service programs) in each of the 50 states and the District of Columbia, as well as a national overview.

Some findings with particular relevance to the lives of children from birth to three and their families include:

- In 32 states, the maximum AFDC cash benefit for a single parent with two children with no other income is below 50 percent of the poverty line.
- Only 28 states provide AFDC benefits to two-parent families.
- Nationwide, fewer than half of the women and children eligible for WIC participation are served under the program. However, at the beginning of 1988 10 states and the District of Columbia had begun to supplement federal WIC funds.
- A much lower proportion of poor children are on AFDC now than in 1979. From 1979 to 1986, the number of children living in poverty increased from 9.9 to 12.7 million, while the number on AFDC remained essentially unchanged.

Teenage Pregnancy: An Advocate's Guide to the Numbers (1988)—Karen Pittman and Gina Adams (Adolescent Pregnancy Prevention Clearinghouse, Children's Defense Fund, 122 C Street, N.W., Washington, D.C. 20001) $7.45.

Adolescent pregnancy, according to the authors of this report, is a "poorly understood, loosely defined set of issues that are very much subject to interpretation, misenterpretation, and debate ... A complicated continuum of facts and trends is made more difficult to understand and interpret by the substantial

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difference in numbers, rates and trends by age, gender, race and ethnicity, and geographic area."

Designed as a reference document, the guide uses charts, tables, glossaries of terms, and data analyses to present trends for the total adolescent population, racial and ethnic differences, state and local birth data, and state and local birth data by race and ethnicity.

Prenatal Care: Reaching Mothers, Reaching Infants (1988)—Sarah S. Brown, editor (National Academy Press, 2101 Constitution Avenue, N.W., Washington, D.C. 20418) $19.95.

In the summer of 1986, the Institute of Medicine convened an interdisciplinary Committee to Study Outreach for Prenatal Care. Although the Committee was asked to focus particularly on ways of identifying pregnant women and linking them to prenatal care (casefinding) and on services helping them remain in care once enrolled (social support), it became evident that outreach could not be studied in isolation from the larger maternity care system in which it occurs. Indeed the Committee concluded that the complicated network of publicly and privately financed services through which women in the United States obtain prenatal, labor and delivery, and postpartum care is "fundamentally flawed, fragmented and overly complex." The Committee concluded that in the long run, the best prospects for improving use of prenatal care lie in fundamental reform (*not* incremental changes) in the maternity care system.

The Commitee report includes 14 major recommendations. The first states that the nation should "adopt as a new social norm the principle that all pregnant women—not only the affluent—should be provided access to prenatal, labor and delivery, and postpartum services appropriate to their need." The Committee also recommends that outreach should be funded only when it is linked to a highly accessible system of prenatal services, or as part of a comprehensive plan that includes removing financial barriers to care, making certain that basic system capacity is adequate for all women, improving prenatal services at the delivery site, and increasing public information and education about prenatal care.

Saving Lives and Money: Preventing Low Birthweight (1988)—Martha P. King (National Conference of State Legislatures, 1050 Seventeenth Street, Suite 2100, Denver, Colorado 80265) $10.00.

Directed toward state legislators, this publication summarizes recent findings and recommendations on low birthweight and its reduction, with an emphasis on ensuring prenatal care. The text describes federal assistance programs that are available to states and how states are paying for expanded prenatal care. An appendix describes initiatives in California, Massachusetts, Michigan, South Carolina, Florida, Kansas, Utah and New Jersey. Those efforts include developing successful prenatal care services; establishing prenatal care as a right; preventing preterm labor through education; allocating limited resources to reach high-risk populations; and using data to plan programs and inform legislators.

FLORENCE SHARP

Guidelines for Perinatal Care, Second Edition (1988)—Fredric D. Frigoletto and George A. Little (American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, Publication Department, P.O. Box 927, Elk Grove Village, IL 60009) $30.00.

The conviction that pregnancy outcome can most effectively be improved by integrating the skills and knowledge of multiple disciplines provides the foundation for this text, which was written, revised and reviewed by members of the AAP Committee on Fetus and Newborn and the ACOG Committee on Obstetrics: Maternal and Fetal Medicine. The guidelines are designed for use by all personnel who are involved with the care of pregnant women, their fetuses, and neonates in both hospitals and medical centers. The manual offers guidelines for the organization of perinatal health care, physical facilities for perinatal care, personnel, the content of services, follow-up care, control of infections in obstetric and nursery areas, maternal and newborn nutrition, interhospital care of the perinatal patient, and evaluations of perinatal care. New sections in this second edition address ethics, fetal therapy and AIDS among other topics; substantive changes in recommendations are made regarding fetal monitoring, the role of forceps, and management of herpes.

Drugs, Alcohol, Pregnancy and Parenting (1988)—Ira J. Chasnoff, editor (Kluwer Academic Publishers, P.O. Box 358, Accord Station, Hingham, MA 02018-0358) $44.50.

Recognizing that in the last few years problems associated with drug use in pregnancy have become endemic, the contributors to this volume seek to integrate information from multiple disciplines in order to understand the impact of drug use on both young children and parents. The editor emphasizes that although most drugs of use and abuse do not produce congenital malformations there are definite behavioral and neurological effects of drug use in pregnancy that place the newborn, infant and child at risk for developmental abnormality. A social environment including drug-using caretakers also poses serious developmental risks to children.

The 21 contributors to the book discuss topics that include the neonatal effects of maternal use of marijuana, cigarettes and cocaine during pregnancy; AIDS in pregnancy and the newborn; breastfeeding by the chemically dependent woman; a treatment model of nursing care for pregnant chemical abusers; and parenting dysfunction in chemically dependent women.

Spaces for Children: The Built Environment and Child Development (1987)—Carol Simon Weinstein and Thomas G. David, editors (Plenum Publishing Corporation, 233 Spring Street, New York, NY 10013) $39.50.

The contributors to this book include designers and architects, child advocates, and researchers from developmental psychology, environmental psychology, education and sociology, all of whom believe that the developmental process can be influenced by characteristics of the physical setting and that systematic knowledge about children and their interaction with the built environment can be used to improve the design of children's settings.

A chapter by Anita Olds on designing settings for infants and toddlers addresses the needs of both handicapped and able youngsters and establishes criteria for facilities that support the needs of both children and caregivers. Laura Johnson offers guidelines for child-oriented home environments, including family day care homes. Harold Proshansky and Abbe Fabian discuss the concept of "place identity," a substructure of the child's self-identity that is rooted in the child's experience with rooms, clothes, playthings, and other objects and spaces that support its existence.

Caring Spaces, Learning Places: Children's Environments That Work (1988)—Jim Greenman (The Exchange Press, Inc., P.O. Box 2890, Redmond, VA 98073) $29.00.

"An environment," notes Jim Greenman, "is a living, changing system (that) includes the way time is structured and the roles we are expected to play. It conditions how we feel, think and behave; and it dramatically affects the quality of our lives." Greenman sees the "all too ubiquitous church basement" as a symptom of the lack of resources allocated to young children in this society and intends his book, premised on the importance of "good settings" for adults and children, as a resource for people who create, adapt and cope with group care settings for young children.

The environmental needs of infants and toddlers in groups, and of their caregivers, are addressed in a special chapter. Another chapter analyzes children's settings along a range of dimensions which include "softness" and privacy as well as safety. Greenman also addresses the practicalities of buildings and sites, interior architectural features, spaces for caregiving routines, storage, room arrangements, indoor and outdoor learning environments, and the process of changing the status quo.

Raising Salaries: Strategies That Work (1988)—Nancy Whitebook, Caro Pemberton, Joan Lombardi, Ellen Galinsky, Dan Bellon, and Bryn Fillinger (Child Care Employee Project, P.O. Box 5603, Berkeley, California 94705) $5.00.

Funded by a grant from the A.L. Mailman Family Foundation, this report outline examples of child care centers, child care systems, cities, counties and states that have developed new policies aimed at improving compensation for child care staff. In each of these diverse examples, the people involved had to identify the potentially available resources and the decision makers who had the power to allocate those resources before they could devise strategies likely to be effective in their particular situation. The authors recognize the need for child care staff and parents to join together as advocates for better child care and recall the examples of nursing and teaching associations, which have worked to meet the economic needs of their membership while setting quality standards for professional services.

Child Abuse and Neglect: Biosocial Dimensions (1987)—Richard Gelles and Jan Lancaster, editors (Aldine de Gruyter, 200 Saw Mill River Road, Hawthorne, NY 10532) $21.95, paper.

This volume is the third in a series sponsored by the Social Science Research Council's Committee on Biosocial Perspectives on Parent Behavior and Offspring Development. The multidisciplinary committee, formed in 1980, reflects the conviction that a biosocial perspective takes into account "the biological substrate and the social and environmental contexts as determinants of behavior;" the perspective also pinpoints areas in which contemporary human parental behavior exhibits continuities with, and departures from, patterns evident throughout human history.

This volume, including contributions from 20 scientists from the disciplines of anthropology, evolutionary biology, history, human development, family studies, primatology, psychiatry, psychobiology, psychology and sociology, attempts to present and integrate recent advances in biological and social science research on parental behavior and "parental investment" (defined as any investment by a parent in an offspring that increases the recipient's fitness at the cost of parental capacity to invest elsewhere). Child abuse, including infanticide, is described in nonhuman species, in a range of cultures, and in various periods of history. Through attention to social and ecological issues, the biosocial perspective is seen as helpful in predicting when and where a pattern of abuse is expectable at high frequencies.

The Role of Culture in Developmental Disorder (1987)—Charles M. Super, editor (Academic Press, 1250 Sixth Avenue, San Diego, CA 92101) $45.00.

This volume is designed to reflect the growth of transdisciplinary interests among investigators and policymakers who appreciate that "the reality of human development is a seamless web without dotted lines to demarcate academic territory." Developmental problems are seen as experienced by individuals, but with quality and frequency "strongly shaped by the human environment in ways that will not be obvious from examination of individuals alone."

Thus, for example, Konner and Super argue that the sleeping and feeding arrangements typical of families in the industrial West may contribute to vulnerability of some infants, already at biological risk, to sudden infant death syndrome. In a critique of bonding theory, Scheper-Hughes draws on preliminary data from a study of infant mortality and selective neglect in a Brazilian shantytown; she suggests that "bonding is always complex, culturally constructed, and individually negotiated depending on the kinds of choices and options available to the mother and her evaluation of the costs, risks and benefits of emotional investment in her offspring."

Pre- and Perinatal Psychology: An Introduction (1987)—Thomas R. Verny editor (Human Sciences Press Inc., 72 Fifth Avenue, New York, NY 10011-8004) $36.95.

This volume represents a selection of 18 papers presented at the First International Congress on Pre- and Perinatal Psychology, held in Toronto in 1983 (the fourth international congress will be held in Amherst, Massachusetts in August, 1989). Contributions address such topics as the embryological development of the auditory system, consciousness at birth, alternative childbirth practices, and psychotherapeutic approaches designed to address problems that originated during gestation or the postnatal period. W. Ernest Freud reviews research on prenatal attachment and bonding. Judith Kestenberg describes a preparation for parenthood course that combines "kinesthetic empathy" with the fetus with attention to physical and emotional states of comfort and discomfort of the pregnant woman.

The editor of the volume concludes: "A child 6 months after conception (i.e. by the end of the second trimester) is a feeling, sensing, aware and remembering human being. The implications of this knowledge for pregnancy, obstetrics, pediatrics and psychiatry are of course tremendous, and we are just beginning to explore them."

Nature and Nurture during Infancy and Early Childhood (1988)—Robert Plomin, John C. Defries and David W. Fulker (Cambridge University Press, 32 East 57th Street, New York, NY 10022) $44.50.

According to its authors, the goal of this book is to explore the origins of individual differences in behavorial development during infancy and early childhood. Quantitative genetics is seen as providing the basis for a general theory of the etiology of individual differences. New data are presented from the Colorado Adoption Project, one of the two long-term longitudinal quantitative genetic studies of behavioral development. Discarding old notions of genes as static, unchanging influences, the authors emphasize the role of genetics in developmental change as well as continuity.

Advances in Infancy Research, Volume 5 (1988)—Carolyn Rovee-Collier and Lewis P. Lipitt, editors (Ablex Publishing Corporation, Norwood, New Jersey 07648) $32.50, personal orders; $55, institutional.

This volume is the fifth in a continuing series devoted to the presentation of innovative research on human or animal infancy. Included in this volume are "A Neuropsychological Perspective on Infant Sensorimotor Development" by George Michel; "Olfactory Influences on Mother-Infant Interactions" by Richard Porter and colleagues; "A Multifactor Model of Infant Preferences for Novel and Familiar Stimuli" by Michael Hunter and Elinor Amos; "Immunological Consequences of Psychological Disturbance and Maternal Loss in Infancy" by Christopher Coe and colleagues; "The Development of Auditory Pattern Perception Skills" by Barbara Morrongiello; and "Infants' Perception of the Affordances of Expressive Behaviors" by Arlene Walker-Andrews.

Maternal and Child Health Practices, Third Edition (1988)—Helen M. Wallace, George M. Ryan, and Allan C. Oglesby, editors (Third Party Publishing Company, P.O. Box 13306, Montclair Station E, Oakland, CA 94661-0306) $27.95.

The 70 contributors to this textbook address policies and issues in maternal and child health; basic services in maternal and child health; reproductive health care; child and adolescent health care; children with special needs; and a global overview of the health of women and children. The editors note that extensive social, technical, programmatic and political changes have taken place since the previous edition of this textbook was published in 1982. This edition, therefore, includes an increased emphasis on the health needs and care of adolescents, case management, ethical issues in the provision of services, home care for technology-dependent children, and advocacy for improved health care for women, children and families. Chapters on legislation, demographics, health status, nutrition, day care and evaluation are updated.

Call for Papers

An **International Conference on Early Education and Development,** sponsored by UNICEF, High/Scope Foundation and other organizations, seeks abstracts for presentations. The conference will take place in Hong Kong, July 31-August 4, 1989; **deadline for submission is January 15, 1989.** For information contact International Conference Consultants, Ltd., 57 Wyndham Street, 1st Floor, Central, Hong Kong, Tel: 5-253271, FaxL 5-8400564.

The **Boston Institute for the Development of Infants and Parents, Inc. (BIDIP)** invites proposals for workshop presentations on a wide variety of infancy-related topics for its annual conference, planned for November 3 and 4, 1989. **Proposals must be received by March 30, 1989.** For information write to Arnold M. Kerzner, M.D., President, BIDIP Conference, 26 Trapelo Road, Belmont, MA 02178.

Early Education and Development, a new journal published by Psychology Press of Brandon, VT 05733-1007, is accepting research-based manuscripts dealing with early education issues, techniques, instruments, and programs. Practical implications for professional early education supervisors must be emphasized. Contact Richard R. Abidin, Editor, University of Virginia, Curry Programs in Clinical and School Psychology, 405 Emmet Street, Ruffner Hall, Charlottesville, VA 22903-2495.

Conference Call

January, 1989

January 9-13: *The National Institute for Alternative Care Professionals* will hold a conference in St. Petersburg Beach, Florida entitled "The Foster Care Professional: Confronting the Challenges of 1989." Workshop topics will include children with AIDS, medically complex children, training foster parents, and separation trauma, among others. Contact Valerie Warnock, Director of Operations, NIFACP, 10100 Elida Road, Delphos, OH 45833, tel: (419) 692-6749.

January 30-February 3: *Contemporary Forums* will sponsor a conference on "Perinatal Dilemmas" in Fort Lauderdale, Florida. Contact Contemporary Forums, 530 LaGonda Way, Suite E, Danville, CA 94526, tel: (415) 820-2800.

January 27-29: *The Institute for the Advancement of Human Behavior* and the *Pre and Perinatal Psychology Association of North America* will sponsor a conference in Newport Beach, California entitled "The Power of Pre and Perinatal Experience: Maximizing Human Potential Throughout Life." Faculty will include Thomas Verny, Stanislav Grof, David Chamberlain, Elizabeth Noble, Graham Farrant, Barbara Findeisen, William Emerson and Ina May Gaskin. For information, write IAHB, P.O. Box 7226, Stanford, CA 94309.

February, 1989

February 4-10: The *Nursing Child Assessment Satellite Training Program (N-CAST)* will hold a training program in Seattle, Washington that includes training in assessment of infant interaction, feeding interaction, teaching interaction, and the home environment, and in intervention approaches. Kathryn Barnard, Nia Johnson-Crowley, Charlene Snyder and Anita Speitz are instructional faculty. For information contact Georgina Sumner, NCAST, University of Washington, WJ-10, Seattle, WA 98195, tel: (206) 543-8528.

February 7-10: The *North Central Florida Maternity and Infant Care Project of the University of Florida* will hold an intensive short course in Gainesville, Florida on maternal/perinatal nutrition, with an emphasis on pregnancy and lactation. Contact Diane Dimperio, c/o NCF-MIC, 730 N. Waldo Road, Building A-Suite B, Gainesville, FL 32601, tel: (904) 392-4491.

February 12-14: The *Infant-Parent Institute* will hold its annual intensive seminar on "Loss and Separation in Infancy" at a retreat site near Grand Rapids, Michigan. Institute Director Michael Trout will use film and case studies to examine the implications of early loss for child welfare, day care, infant hospitalization and parental divorce or death. Contact the Infant-Parent Institute, 328 North Neil Street, Champaign, IL 61820, tel: (217) 352-4060.

February 15: *ACLD, Inc.*, an association for Children and Adults with Learning Disabilities, will sponsor a symposium on research in infant assessment, to be held prior to its 26th international conference in Miami, Florida. Speakers will include Lori Annes, Richard Q. Bell, Frank Duffy, Dennis and Victoria Molfese, David Bellinger, Barry Lester, and Linda Siegel. Contact Neurosciences Symposium, ACLD National Office, 4516 Library Road, Pittsburgh, PA 15234.

February 24-25: *Children's Hospital Oakland* will sponsor a conference in Berkeley, California on health care for foster children. Faculty will include Robert Apteker, Peggy Baxter, Angela Blackwell, David Chadwick, Jorge Colapinto, Leonard Edwards, Randall Feltman, James Garbarino, Neal Halfon, Jean McIntosh, Sue North, Jeree Pawl, Edward Schor and Laren Sater. For information, write or call Kim I. Leadon, Continuing Medical Education, Children's Hospital Oakland, 747 52nd Street, Oakland, CA 94609, tel: (415) 428-3021.

February 27-March 1: The *Research and Training Center for Children's Mental Health, Florida Mental Health Institute,* will hold a research conference in Tampa, Florida entitled "Children's Mental Health Services and Policy: Building a Research Base." Contact Dr. Al Duchnowski, Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd., Tampa, FL 33612-3899, tel: (813) 974-4500.

February 27-March 3: *Contemporary Forums* will sponsor a conference on "Perinatal Dilemmas" in Snowmass, Colorado. Contact Contemporary Forums, 530 LaGonda Way, Suite E, Danville, CA 94526, tel: (415) 820-2800.

March, 1988

March 1-3: The *National Association of Child Care Resource and Referral Agencies (NACCRRA)* will sponsor a conference in Orlando, Florida entitled "New State Visions for Child Care." Topics to be addressed include integrating child care and welfare reform, building a diversified funding base, assuring parental choice and other issues. Contact Dee Rabehl, NACCRRA, 2116 Campus Drive SE, Rochester, MN 55904, tel: (507) 287-2020.

March 15-18: The *National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)* will hold its 10th annual Nursing Conference on Pediatric Primary Care in Orlando, Florida. Dana Hughes will be keynote speaker. Workshops will address pain in children, the feeding relationship, health issues in day care and other issues. For information contact Anthony J. Jannetti, Inc., N. Woodbury Road, Box 56, Pitman, NJ 080701, tel: (609) 589-2319.

March 19-20: The *Pediatric Research and Training Center at the University of Connecticut Health Center* will hold its 4th annual Early Intervention Conference in Cromwell, Connecticut. Speakers will include Don Bailey, Pip Campbell, Marilee Comfort, Carl Dunst, Phillip Strain, and G. Gordon Williamson. Contact Cheryl LeTellier, Pediatric Research and Training Center, Division of Child and Family Studies, Department of Pediatrics, University of Connecticut Health Center, The Exchange—Suite 164, Farmington, CT 06032, tel: (203) 674-1485.

March 26-31: The *9th International Congress on Pre and Perinatal Psychology and Medicine* will be held in Jerusalem, Israel. Topics will include fetal memory, antenatal diagnostic techniques, cross-cultural perspectives on pre and perinatal psychology, and psychoneuroendocrinology, among others. Contact ISPP Congress Secretariat, c/o International Ltd., P.O. Box 29313, 65121 Tel-Aviv, Israel, tel: (03) 6544641, Telex: 33554 Intur IL.

March 31-April 4: The *American Orthopsychiatric Association (ORTHO)* will hold its 66th Annual Meeting in New York City on the theme "Changing Families, Changing Responses: Reorienting Services and Programs." Edward Zigler will receive the 12th Annual Blanche F. Ittleson Lecture Award. A joint ORTHO-NCCIP one-day institute on Friday, March 31, will include G. Gordon Williamson, Jeree Pawl, Rebecca Shahmoon Shanck, Joanna Erikson, Sally Provence and Emily Schrag. For information, contact ORTHO, 19 West 44th Street, Suite 1616, New York, NY 10036, tel: (212) 354-5770.

April, 1989

April 5-8: The *Canadian Child Day Care Federation* will sponsor a National Child Day Care Conference in Winnipeg, Manitoba with workshops, discussions, and visits/tours. Contact Canadian Child Day Care Federation, 120 Holland, Suite 500, Ottawa, Ontario K1Y 0X6, Canada, tel: (613) 729-5289.

April 17-18: The *Michigan Association of Infant Mental Health* will hold its 13th Annual Meeting in Ann Arbor, Michigan, with the theme "Expanding Our Approaches with Families: Attachment, Intervention and Social Policy." For information contact Ann Saffer, 2340 Hichman Road, Ann Arbor, Michigan 48105, tel: (313) 994-8168.

April 27-28: The *Family Child Learning Center* of Children's Hospital Medical Center of Akron will hold a conference in Akron, Ohio entitled "Early Intervention: The Roles of Families and Professionals." Speakers will include Carl Dunst, Kathleen Bishop, Georgia DiGangi, Rebecca Fewell, Winnie Dunn, Susan Harris, and Mary Beth Bruder. For information, contact Jean Markewski, Family Child Learning Center, 90 West Overdale Drive, Tallmadge, OH 44278, tel: (216) 633-2055.

April 27-30: *Save the Children* will hold its 12th Annual Family Day Care Technical Assistance Conference in Atlanta, Georgia. The Child Care Food Program Sponsors' Forum will be held in conjunction with the conference. Contact Joe Perreault, Save the Children, 1340 Spring Street, N.W., Suite 200, Atlanta, GA 30309, tel: (404) 885-1578.

April 27-29, May 3-5, June 1-3: *Contemporary Forums* will hold national conferences on neonatal nursing in Philadelphia, Pennsylvania; Denver, Colorado; and Anaheim, California. Contact Contemporary Forms, 530 LaGonda Way, Suite E, Danville, CA 94526, tel: (415) 820-2800.

May, 1989

May 11-13: The *Infant Development Association*, the *National Center for Clinical Infant Programs, six California state agencies* concerned with young children and families, and other professional and community organizations will sponsor a national conference in Los Angeles, California. The conference theme is "Moving From Research to Practice: Directions for Implementing Infant Services in the Nineties." Write to Karen Finello, Infant Conference '89, UAP-CHLA, P.O. Box 54700, Los Angeles, CA 90054.

July, 1989

July 31-August 4: An *International Conference on Early Education and Development (0-6 years)* entitled "Childhood in the 21st Century" will be held in Hong Kong, with the support of UNICEF and High/Scope Foundation among other organizations. Conference topics will include the special needs of infants, training of early childhood personnel, family support, and policy issues, among others. For information, contact Tania Woo, International Conference Consultants, Ltd. 57 Wyndham Street, 1st Floor, Central, Hong Kong.

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Zero to Three

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Infants in Institutions Revisited

by
Sally Provence

In 1962 my colleague Rose Lipton and I said in the introduction to *Infants in Institutions:* "The family . . . is the setting in which babies can best be provided with the care and influences that support and foster good development. It becomes increasingly hard to provide such care as we get farther away from this model. The infant's needs are multiple and complex, and it is difficult or perhaps impossible to meet them adequately under conditions of group care." (p. xiii)

Over the ensuing years I have had many occasions to reexamine that statement and have moved somewhat from that position. I would now say it is difficult, but not *necessarily* impossible, to meet the infant's needs in group care (Provence, 1967). Unfortunately, institutional care has rarely been so designed and provided that it meets the physical, social, emotional and cognitive needs of infants and young children in a way that approaches the nurturing, stimulating and protective atmosphere of a good family environment.

The centrally important issue in residential care of infants, whether in group homes or larger institutions, is the creation of an environment and set of experiences that will promote the health and development of *each* child. The care provided must address each infant's unique needs as well as the needs he shares with other children. Thus we begin by creating a social, emotional and material environment that, according to our best knowledge, is likely to meet the developmental needs of children of a particular age and/or with a particular kind of illness or dysfunction. Then we modify and individualize care in accordance with the state and condition of *this* child at *this* time in his life. Because this approach is basic to all of the healing professions and to education as well, I doubt that anyone would deny its importance in principle. The problem is that when children are brought together in groups, individual needs, assets and sensitivities are often insufficiently attended to in the day to day care.

NANCY P. ALEXANDER

It is important to distinguish the issue of deprivation of maternal care from other aspects of institutional care

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National Center for Clinical Infant Programs *733 15th St., N.W., Suite 912, Washington, D.C. 20005* *(202) 347-0308*

of infants and young children. The impact of maternal deprivation was studied as far back as the thirteenth century when Frederick II, German King and Emperor of The Holy Roman Empire, directed an experiment described in a quotation from Salimbene (Provence and Lipton, 1962) "..he wanted to find out what kind of speech and what manner of speech children would have when they grew up if they spoke to no one beforehand. So he bade foster mothers and nurses to suckle the children, to bathe and wash them but in no way to prattle with them or speak to them, for he wanted to learn whether they would speak the Hebrew language, which was the oldest, or Greek or Latin, or Arabic, or perhaps the language of their parents, of whom they had been born. But he laboured in vain, because the children all died. For they could not live without the petting and joyful faces and loving words of their foster mothers. And so the songs are called 'swaddling songs', which a women sings while she is rocking the cradle to put the child to sleep, and without them a child sleeps badly and has no rest."

> *It is important to distinguish the issue of deprivation of maternal care from other aspects of institutional care. In the institutions we studied, the absence of a specific maternal figure meant the loss of continuity of physical, social and emotional care. The lack of time spent in care for each infant meant that there was far from enough mothering by anyone.*

When my colleague Rose Lipton and I began a study in 1957 of infants living in a foundling home there was already a substantial body of more recent literature on the adverse effects of prolonged deprivation of maternal care on the personality development of children. Some modern researchers had discovered, as had Frederick II, that maternal deprivation affected the physical health, survival and development of very young children. (Bakwin 1942, 1949; Bowlby 1951; Brodbeck and Irwin 1946; Freud and Burlingham, 1944; Goldfarb 1943, 1945; Spitz 1945.)

The findings of Anna Freud and Dorothy Burlingham came from their experience in creating and running the Hampstead Nursery in World War II London, an effort which represented a giant step forward in better care for children separated from their families. In *Infants Without Families* (1944) Freud and Burlingham summarize "Although residential, (the nursery) is not run on institutional lines. It tries to reestablish for the children what they have lost: the security of a stable home with its opportunities for individual development." (p. 7) They conclude: "There are realms in the infant's life where the residential nursery can be helpful by creating, very much on the lines of the nursery school, excellent conditions for development as health, hygiene, development of skills and early social responses. There are other realms, where it is important for residential nurseries to recognize their limitations, as in emotional life, character development; they will then face, and more effectively fight, the consequences of such limitations." (p. 127) John Bowlby's 1951 monograph, *Maternal Care and Mental Health*, was both a detailed survey of the world literature on the subject and an indictment of nurseries and other institutions, including hospitals, for their failure to provide the kind of care and attention that would adequately support the development of children. His report had a significant influence in improving the care of infants and children in foundling homes and hospitals.

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In our study, the development of 75 infants reared in the institution was compared in detail with 75 infants reared in foster families during the first year of their lives. We also reported follow-up data on a group of 14 children ages 3 to 5 years who had lived in the same institution for periods ranging from 9-29 months. In the study we detailed the daily lives of the infants in order to highlight what was present and absent in the infant's experience; we measured, rated and described the development and behavior of the infants; through observation and interviews with child care staff and administration, features of the institutional environment were documented in respect to staff/child ratio, child care practices and the attitudes of staff members.

The major finding in regard to test scores (developmental quotients) was that delay in developmental age was progressive in the infants living in the institution throughout the first year: in comparison with the family infants they looked progressively worse between 4 and 12 months. There were individual differences in the rate of decline in the scores of institutionalized infants, but there was a remarkable consistency in the patterns of development. The report contains a detailed account of aspects of behavior in which there was little or no delay; those in which there was moderate to severe delay; and those in which there was unusual or deviant behavior. Most impressive were the delays and deviant behavior in emotional development, language, social development and non-verbal problem solving. Gross and fine motor development were less adversely affected, although there were mild delays or deviations even in these areas.

In the institution we studed beginning in 1957, the administrative staff and caregivers included not one person with training in the development of infants and pre-school children.

The caregivers in both nurseries seemed to like the babies and gave as much of themselves as they could under the conditions imposed by the policies and practices of the institution and their own personalities and available energy. But the administrative staff and the caregivers included not one person with training in the development of infants and pre-school children. The lack of good quality personalized care was noteworthy: the interest and emotional involvement of the carergiver could only in very rare instances be compared with the relationship between a mother and her own baby. Moreover, the routines of the institution were only occasionally related to the needs of a given infant at a specific moment. The infants had very few experiences of having caregivers respond to their communication (e.g. the discomfort of hunger, or the communication with social partner) at the time they were expressed; thus many opportunities for learning and for establishing a relationship with a maternal figure were lost. The absence of a specific maternal figure meant loss of continuity of physical, social, and emotional care. The lack of time spent in the daily routines of care for each infant meant that there was far from enough mothering by anyone.

Some details illustrate the extent of deprivation in the institution. The physical environment was one of order, cleanliness and such unusual quietness that it was difficult to realize that 75 children (average census) from age 4 days to 6 years lived there. The infants were housed in two separate nurseries; cribs and clothing were simple but adequate. Diet and medical care were conscientiously provided. Infants were fed in their cribs with bottles propped. When cereals, fruit and vegetables were added to the diet, they too were usually fed in propped bottled with enlarged holes in the nipple, rather than being given by spoon. Infants under 4 months were rarely out of their cribs except for bathing and dressing (once daily) and diapering (3-4 times daily) which were done on a table in the central work area. For those older than about 4 months rattles and "cradle gyms" were suspended across the cribs, and they might occasionally be put in an infant seat or playpen. Each infant under 9 months shared the time and attention of the caregiver with 7 to 9 others for the 8 hour day. For the remaining 16 hours there was one caregiver for 32-35 babies. The twenty (average census) 9-24 month olds lived in a large, uncubicled room, cared for by two attendants during the day with a third person assisting for the three daily meals. There was only an occasional opportunity for self-feeding in a high chair. Each infant or toddler was fed in his crib lying on his back or sitting up in the corner of the crib as an attendant spooned the food as efficiently as possible. "Play periods" (2 hours morning and afternoon) were with other children on floor or playpen, rarely facilitated by staff. The children had no experience outside the walls of the nursery except on rare occasions when they were taken out for a medical procedure or for the observation and testing that were a part of the study.

The study was sobering experience for the investigators. Looking closely and over many months at the institutionalized infants and their daily lives compared with infants with foster mothers, we were fully persuaded of the sharp contrasts in their experiences. The many ways in which they were deprived of those experiences that facilitate healthy mental and emotional development made a lasting impression and led us to join those who were beginning to define more clearly and speak more forcefully for developmentally appropriate care.

In the years since *Infants in Institutions* was published, the field of infant development has moved from global statements and conclusions about, for example, separation or institutionalization or maternal deprivation to an appreciation that specific factors that operate under these conditions must be taken into account. For example, we know that what has happened in the child's life before placement in an institution, the specific influences of life in that setting and what goes on after the child is returned to a family all play a part in both short and long term developmental outcome. We have learned to ask ourselves questions about the baby's characteristics, the specific factors in the environment in which he lives and how these interact.

One illustration of the influence of increasing knowledge on the care of children in groups is in the day care field. Since the late 1960's there has been increasing emphasis on how environments, including the human environment, that facilitate the development of infants and young children can be designed and carried out in day care settings. Furthermore, the awareness that knowledge about the more easily measured levels of development such as motility, cognition, language and social skills must be integrated with the less easily assessed information about emotional development and the inner life of the child exert more influence on recommendations about child care. The current respect for the multiple, interacting lines of development and of the complex mutual influence of biological and experiential factors is a reflection of how much we know and of how much there remains to be learned (Yarrow, 1961).

Residential care may be a placement of choice for infants in some circumstances: some fragile infants who no longer need hospital care; infants of dysfunctional parents; and healthy infants without families.

Given the current state of knowledge about infant development and our appreciation of the many and complex experiences that constitute good caregiving, we may find that residential care may be a placement of choice for infants in some circumstances.

For some fragile infants, especially those made doubly vulnerable by such problems as the impact of a mother's drug dependence, residential care is often the treatment of choice when hospital care is no longer needed. Such care should be organized as an active therapeutic program which includes carefully designed, individualized treatment as well as general developmentally appropriate care. The duration of residential care for each child should be determined by the time at which he is judged to be healthy enough and well organized enough (at whatever level) that home care by parents or foster parents has a good chance of success.

Infants of dysfunctional parents may benefit from temporary residential care. Much that is therapeutic, aimed at restoring infants to their parents, can be accomplished through residential care for infants accompanied by intensive assistance to parents. In such efforts, the institution takes responsibility for child care, but works to keep alive the relationship between infant and parent and if possible to reunite them. Again, the service is more than a "shelter" concept. It involves action that not only protects and facilitates the baby's development, but includes the preparation of infant and parent or foster parent for taking care of the child.

Residential care may be appropriate for healthy infants without families until stable living situations can be assured. Our belief that children grow up best in families reflects knowledge and wisdom as well as preference and tradition, but this should not blind us to the disadvantages and sometimes harm that occurs when infants "bounce" from one living situation to another. A series of short term foster home placements, for example, with the accompanying disruptions in continuity of care and human relationships is more likely to be damaging than not. Good residential care, even for healthy infants, is preferable to such disruptions.

The care of infants not one's own is a responsibility of the first magnitude. High standards of care and practice have never been more important for the future of children. In this context, attention to how the needs of infants can be met and their development promoted in situations of residential care must be addressed thoughtfully and with the expectation that residential care has a valid place in the spectrum of services needed for the well being and development of infants and young children.

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The Infant and Toddler Therapeutic Shelter: A Secure Base

by
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Children's Institute International
Los Angeles, California

- **Lynn and Chrystal, identical twins, were born withdrawing from heroin and experiencing the frightening effects of a difficult-to-identify "designer" street drug. Premature, and small for gestational age, they both endured violent convulsions, uncoordinated sucking responses, and a severe esophageal reflux problem. Frequently inconsolable, the twins fought to achieve some level of homeostasis.**

- **Shortly following her family's arrival in Los Angeles, twenty-one month old Tynessa was awakened by her mother's screams and a blanket of smoke. The single hotel room her family had struggled so hard to rent with shelter vouchers was engulfed in flames. Tynessa's father jumped from the first floor window and coaxed Tynessa's mother to throw Tynessa to him and jump to him herself. Both parents were hospitalized with fractures, but Tynessa was essentially unharmed.**

- **Angela, whose mother suffers from a multiple personality disorder, was accustomed to "living" on Los Angeles Rapid Transit District buses. At thirteen months, Angela was very withdrawn, developmentally delayed and severely malnourished.**

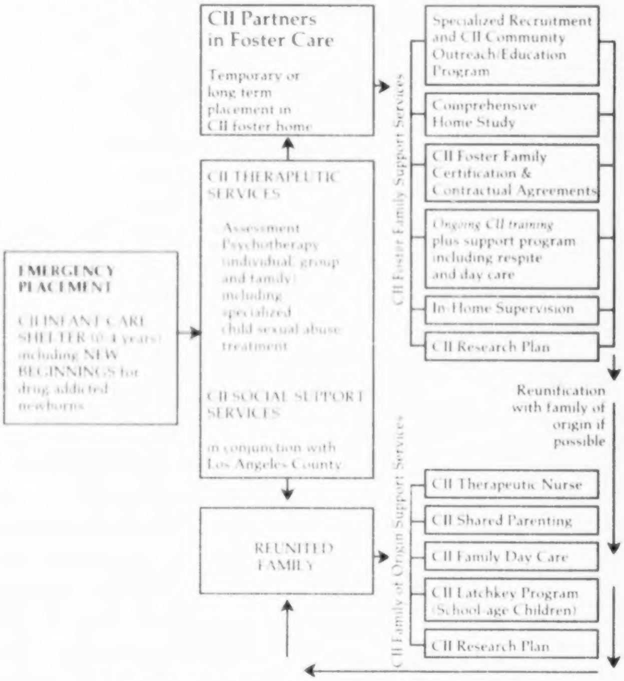
- **Tim had lived in six different homes in his brief nine months of life. His fourteen-year-old mother had left him with extended family members and non-related "babysitters" on a number of occasions and was finally incarcerated in Juvenile Hall. Tim suffered from a severe case of esotropia ("wandering eye").**

- **At two and one-half, Joey was in the custody of the police. A recent recovery from an injury-induced coma was fragile; his need for extensive medical attention for the resultant seizures and numerous other injuries had brought about a storm of media attention when his mother abducted him from a hospital.**

Each of these children has a multi-dimensional, complex cadre of unique strengths and needs. They all share the primary need for a safe, nurturing temporary home. Additionally, they share the weight of intricate acute and chronic health care needs; complicated psychosocial and familial challenges; and significant potential for biological and experiential barriers to development. All of these children, and more than a thousand others, have found a home at Children's Institute International (CII) Infant and Toddler Therapeutic Shelter in Los Angeles, California. The shelter operates on the principle that to interrupt the cycle of child devaluation and family fragmentation for infants and toddlers, all programs, particularly residential programs must be child centered, family focused, thorough, coordinated, clinically sound, future oriented, and timely (Lally, Mongione, Honig, 1988; Greenspan, 1987; Parkes, 1982; Ensher, 1986).

Historical perspective

In the early 1980's, the County of Los Angeles began to experience a rapidly increasing number of very young children who needed protective care (Los Angeles Roundtable for Children, 1986). Coincidentally, economic, societal, and familial trends contributed to the decline of available foster homes, particularly for infants and toddlers (Edelman, 1987; League of Women Voters, 1987). Coupled with the complexity of the care needs of substance-involved, physically traumatized, and significantly neglected small children, these factors created a critical shortage of appropriate homes for the very young child (Ahmann, 1988).


CII Partners in Foster Care
Temporary or long term placement in CII foster home
CII THERAPEUTIC SERVICES
Assessment
Psychotherapy (individual, group and family) including specialized child sexual abuse treatment
CII SOCIAL SUPPORT SERVICES
in conjunction with Los Angeles County
EMERGENCY PLACEMENT
CII INFANT CARE SHELTER (0-4 years) including NEW BEGINNINGS for drug addicted newborns
REUNITED FAMILY
CII Foster Family Support Services
Specialized Recruitment and CII Community Outreach/Education Program
Comprehensive Home Study
CII Foster Family Certification & Contractual Agreements
Ongoing CII training plus support program including respite and day care
In-Home Supervision
CII Research Plan
Reunification with family of origin if possible
CII Family of Origin Support Services
CII Therapeutic Nurse
CII Shared Parenting
CII Family Day Care
CII Latchkey Program (School-age Children)
CII Research Plan

CHILDREN'S INSTITUTE INTERNATIONAL
A Continuum of Care (In and Out-of-Home) for Abused and Neglected Children

To relieve the alarming over-crowding in the county-run shelter, over-stays in hospitals, and dangerously over-populated private foster homes, Children's Institute International, a private non-profit, multi-service agency experienced in serving families for more than eighty years, consented to convert a portion of its Colleagues Infant Care Center to a shelter care home for infants and toddlers. The Colleagues Infant Care Center is an environment created to meet the special needs of children under four years of age (Trumbo, unpublished). Home for years to one of the nation's first therapeutic infant day care programs for at-risk families, the center has a unique design guided by the concept that infant/toddler programs require a family-focused approach carefully structured to support *all* aspects of children's rapid paced development.

The CII Infant and Toddler Therapeutic Shelter Care Program began serving 28 children in September, 1984. In December, 1985, private donors made it possible to expand the shelter to serve 47 children and to accept children twenty four hours a day. Since the opening of the shelter, some significant trends have emerged:

- Each month the average age of our residents has dropped; it is now less than one year.
- The number of previous unsuccessful placements, even for children younger than four, is alarming: an average of 4.3 for our current population.
- More than 75% of our children come from substance abusing families.
- The effects of certain controlled substances during pregnancy are tenacious, possibly life-long, and are detrimental to all phases of development, affecting the type of foster care placement needed.
- Separation of siblings is tremendously damaging but occurs with concerning frequency.
- Many infants and toddlers are returned to the system by foster parents and relatives for re-placement.
- Emotional/behavioral problems must be assessed and attended to as early as possible, if chronic dysfunction is to be averted.
- The time-frames within which the bureaucratic and legal systems function are often damagingly protracted or dangerously abbreviated, with no predictable consistency.

Of CII's residents, 32% come from their families via police or social worker; 31% come from previous placements; 13% come from hospitals; and 14% have been abandoned with unrelated caregivers.

Program design

CII's Infant and Toddler Therapeutic Shelter Care Program is designed to provide twenty-four hour residential care to young children who have been removed from their homes because of suspected abuse or neglect; children who have been released from hospitalization resulting from abuse or neglect; children who have been previously placed in foster care or the home of a relative and whose removal has been requested by caretaker or supervising social worker; or for children whose medical, psychosocial, or familial needs make locating a private foster home difficult. The program offers therapeutic, diagnostic, short-term protective custody for infants and toddlers up to forty-eight months old while appropriate, suitable placement is sought. CII specializes in the care of very young children experiencing:

- drug withdrawal, including hyper-irritability, respiratory distress, high-pitched cry, uncoordinated or underdeveloped sucking and swallowing reflexes, and/or convulsive movements;
- low birth weight, poor or inadequate weight gain, and/or malnutrition requiring careful monitoring of the child's food intake and growth patterns;
- serious physical injuries including cranial trauma, sexual abuse, broken bones, burns, bruises, cuts and abrasions;
- technological dependency on gavage feeding, cardio-respiratory monitors, upper-respiratory pulmonary treatments, and/or orthopedic equipment;
- congenital deformities, neurological abnormalities, perceptual deficits; and
- immunological deficiencies.

CII's children also demonstrate various combinations of conditions associated with the traumas of abuse, neglect and relocation. These include:

- restricted range of emotions, limited expression of pleasure, extensive sadness, indiscriminate rage and hostility, atypical lethargy, dependence or tantruming;
- inappropriate reactions to the presence of (or separation from) strangers or known caregivers;
- severely impaired trust in adults, inconsistent discrimination among adults, and inability or unwillingness to use adults as a source of need fulfillment, affection, and approval;
- delayed vocal interaction leading to impaired receptive and expressive language development;
- over-reaction to (or withdrawal from) social or environmental stimulation; and/or
- disorganized patterns of self-initiation, delaying sense of self-mastery and autonomy.

CII's Infant and Toddler Shelter Care Program is based on the conviction that every child must have the opportunity to establish primary trusting relationships with a carefully limited number of adults; an environment that nourishes and supports all aspects of his or her development; physically nurturing and safe experiences; and age appropriate developmental challenges that facilitate active, child-initiated exploration.

CII program design incorporates stable placement in a primary care CII family, so that each child is fed, changed, dressed, and attended to by only one adult on each shift and is cared for in the same small, predictable family group for his/her entire stay at CII; maintenance, whenever possible, of the parent-child bond and sibling attachments; assessment of the child's previous environment, family circumstances, and physical, emotional and developmental strengths and deficiencies; a timely formulation of individualized, written care plans for each child to address nutritional, health/safety, psychosocial, and developmental needs; and the collection, organization, and maintenance of comprehensive records of the child's personal history.

This individual approach begins with CII's initial contact with the placing agent. Placing agents are encouraged during initial phone contact to bring important special possessions of the child (blanket, teddy, pacifiers, etc.) and as much information as possible about the child's routine daily activities, dietary likes and dislikes, and personal daily rituals. The child is greeted by his new caregiver, given a tour of the facility if age-appropriate, offered something to eat, and generally made as comfortable as possible. Any necessary physical examination, bath, or intimate handling is, whenever possible, guided by the child's comfort level. The child and caregiver label the child's bed and chair and unpack personal possessions together. Belongings, clothing, and any "transitional objects" the child brings are inventoried and labeled and accompany the child throughout his or her stay. If the child arrives with an inadequate wardrobe, CII supplies seasonally appropriate clothing for the child's exclusive use. Combs, brushes, and toothbrushes are assigned and labeled for each child. Personal items, clothing, and special toys are not shared and accompany each child upon discharge.

- **Lynn and Chrystal's first few days here were very difficult for them and for the staff. High-pitched, inconsolable crying; prolonged and frustrating feedings followed by significant spitting up and frantic anxiety-provoking tremors; and rigid, arching postures characterized much of the early interaction between the twins and their caregiver. In spite of much training, support and respite, the caregiver was exhausted, worried, and felt inadequate at the end of each eight-hour shift.**

- **Tynessa, physically quite well in spite of her ordeal, was so sad and disoriented that she clung hopelessly to her primary caregiver and needed to be carried constantly. She would wake frequently screaming and would need to be rocked for several minutes to calm her.**

- **Angela, who refused to be touched, would not eat at a table or sleep in a bed. She was content to eat facing the corner of the nursery on the floor and would sleep curled up in the same corner. She would tolerate her caregiver sitting nearby as long as there was no attempt to interact.**

- **Tim settled into a relationship with his new caregiver too quickly. He behaved as though he had always been at CII. He showed no stranger anxiety or discrimination among adults.**

- **Joey's ghost-like pallor and history of unfathomable long-term ritualistic physical and sexual abuse required many hours of treatment planning and staff processing.**

Children's daily activities and treatment

CII provides a staff-child ratio of one to three for the sixteen hours, seven days a week, the children may be awake and one to 4.5 during the night. To create a family-like environment and insure the physical and emotional well-being of each child, all children are cared for in "primary family groups." Each child has the same caregivers, the same living accommodations and a small family group of peers for his or her entire stay at CII. All siblings are maintained in the same primary family group. "Families" are grouped together in nurseries of not more than four "families," offering children an opportunity to get acquainted with and adjust to the other members of his nursery "community." There is no interaction among or between nurseries in the shelter setting.

Each child is greeted, dressed, fed, bathed, changed, and put to bed, as individually needed, by the same caregiver "parent" in his or her "family" on each shift. It is, therefore, necessary for the child to establish only three primary relationships. All nurseries are self-contained for eating, sleeping, grooming, toileting, and outdoor play. The child's living area, sleeping accommodations, eating location, and possessions are kept personalized and constant to insure a strong sense of individuality, predictability, and security. The children's daily schedules consist of typical age-appropriate activities which meet their individual needs. A consistent schedule framework is followed daily by all shifts of caregivers.

Educational plans include materials and opportunities for infant-initiated sensory exploration, language development, peer interaction, and ever-increasing self-care, within a home-like setting where "parents" provide love, developmental monitoring, ample encouragement, and a "home base" to return to frequently. CII staff are continually training to understand and facilitate language acquisition, processing of perceptual stimulation, cognitive development, and advancement through emotional milestones. But most importantly, CII staff are emphatically encouraged to enrich all caregiver/infant interaction during feeding, grooming, bedding down, caregiver/child "chatting," and play time with stimulating, personalized direct communication.

Clinical, social, educational, and medical services provided to infants and toddlers must be integrated into the overall care and treatment provided in their daily living. Each child has an individualized care plan to insure appropriate psychosocial, health/safety, and nutritional fulfillment. Most treatment goals for this age are met as the child develops independence, trust, and affection while encountering learning opportunities during predictable caregiving routines. Positive self-esteem, autonomy and the beginning of self-discipline are facilitated and encouraged:

- Affection is openly and frequently expressed with smiles, hugs, and conversation.
- Caregiving routines are carried out with respectful handling, full attention, and with constant two-way communication between child and adult.
- Infants and toddlers are always informed of what is about to happen or what is happening.
- Children are offered real choices frequently and their wishes are adhered to.
- Children are allowed to experience conflict and encouraged to handle problems by themselves whenever possible.
- Distressed children are responded to with calm and solace.
- Children are given clear messages of how the caregiver feels and what is expected.
- The beginning stages of socialization are guided by positive communication and encouragement to interact peacefully and positively.

The planned daily in-house directed activities are dictated by age, capabilities and developmental needs of the children. Each child needs to feel close to at least one other person, to feel successful and satisfied, to understand that they can make things happen, to feel in control and free to be curious. Additionally, children need to have clear, direct immediate responses to their active participation in their world. Activity planning, structuring, and timing are regularly reviewed based on assessments of the child's developmental need by the caregiver, supervisor, psychologist, and case manager. Infants and toddlers are gradually introduced to activities in the surrounding community through walks to local stores, florists, barbers, parks and other destinations that have relevance to a very young child's everyday life.

- **Lynn and Chrystal gradually settled into a predictable pattern of eating and sleeping. For the first month their intake and output needed to be monitored daily. Their caregivers discovered certain sleeping routines for each that eventually led to some ability for self-soothing. Carefully limited amounts of food and long, patient feeding rituals eliminated the need for gavage feeding. There was great jubilation when Chrystal, who had consistently been the most irritable, was able to maintain eye contact and return a smile.**
- **Tynessa grew to be comfortable if she could sit within visual range of her caregiver and as long as the caregiver verbally acknowledged her frequently. She began to explore the environment within limits which allowed her to maintain "safe" caregiver contact. She began to ask for "Mama" and seemed reassured by conversation about her mom and dad's recovery.**
- **Angela, captivated by the other children's use of their beds and the "family's" sitting down to eat together gladly, gave up her corner and joined her family at meal times. For several months her appetite was insatiable, and bedtime stories became the high point of her day.**
- **Tim was encouraged to seek out his primary caregiver for comfort and food, and private individual time was scheduled daily. Other staff acknowledged his overtures, but redirected him to his caregiver whenever possible.**
- **Joey seemed for several weeks to have only enough energy to eat, sleep, and occasionally check his surroundings. His weariness was respected by staff, but he was verbally included in all activities.**

Health and development

The provision of comprehensive health care is alarmingly deficient for low resource families in the United States. Unfortunately, this is also true for many children in the protective services system. Children in foster care are likely to have been born with inadequate prenatal care, have often been medically neglected prior to placement, and are known to have a much higher than normal incidence of chronic health problems. High-risk infants and toddlers require a full range of services, periodic assessment, immunization, diagnoses, treatment, and on-going follow-up of their medical and developmental status. Early intervention by professionals knowledgeable in child development, atypical development, and family systems is critical for all children, particularly those in the entry phases of the protective services system.

All CII residents receive a complete physical and developmental screening. When there is suspicion of gross developmental delays or risk thereof, a child receives a comprehensive evaluation at the Frank D. Lanternman Regional Center, which offers a network of preventive services for children from birth to five years old. CII's case manager coordinates with the intake worker at Lanternman and Los Angeles Unified School District. The case manager provides all pertinent historical, developmental, medical, or drug abuse data on parent and child. Following the assessment, the CII case manager coordinates services with the treatment workers from the Regional Center, L.A.U.S.D., or other vendors, as indicated, and informs the LA/DCS case worker.

Daily health care for infants and toddlers at CII is provided twenty-four hours a day by post-position nurses under the supervision of a Pediatric Nurse Practitioner. The center is visited at least once a week by an attending physician, who conducts all exams in the child's home nursery. For special emergencies or diagnostic care, children are transported to Children's Hospital in Los Angeles; there are an average of nine special clinic or emergency room visits per week.

Each child has a complete record established and maintained for the duration of his or her stay. The first portion of the record is a medical chart containing family and birth history, medical consent, personal rights sheet, doctor's orders, doctor's notes, nurse's notes, nurse's treatment record, medication record, and height-weight-developmental records. The second portion of the child's record is a clinical chart that includes any admissions, discharges, changes in information, detailed notes regarding all contact with parents, family members, social workers, court officials, records of monitored visits, assessment information, and any court reports received. Each child has a daily record which includes, minimally, the medical condition, emotional state, dietary pattern and daily accomplishments of each child. These are recorded on each shift. On a weekly basis, the CII social work staff holds rounds with all caregiving staff, recording psychosocial adjustment, special needs, medical and dental treatment, developmental involvement, and short- and long-term goal assessment.

The most important record kept for each child is his/her "life book." A pictorial history annotated by a primary caregiver for each child is maintained—the day of arrival, favorite friends, holiday events, daily activities, first teeth, achievement of developmental milestones, family visits—all are recorded in photographs with brief text so that the child can use the "story" for bedtime, introductions to new future placements or extended family members, or just for fun.

Family involvement

Relationships are critically important to human growth. Relationships with members of one's family, regardless of social-economic status, dysfunctional adaptations, or disabling deficiencies are extremely influential in the development of all children.

High need, low resource families who find themselves involved with the child protective services system face many obstacles to creating the necessary framework to nurture their child. Providing safe, timely, appropriate physical care, consistent supportive affectionate relationships, and opportunities to explore various fields of cognitive, motoric, and emotional adventures is nearly impossible for these families. They face difficulty becoming and remaining drug-free; are weighted by insecurity about parenting and lack of basic parenting skills; and often experience excessive guilt, depression, affective instability, behavior dysfunction, or limited capaticy to attach. When these families are required to cope with lengthy separation and family fragmentation, requirements to relate to multiple service/regulatory systems, unrealistic timetables to establish adequate housing and employment, a dearth of comprehensive long-term treatment services, negative family/social influences, and inadequate support systems, hope for a safe, lasting reunification is highly elusive, at best.

CII strives to do everything possible to strengthen parent-child relationships, improve parents' child care behaviors, and enhance the parents' sense of importance in their children's lives. Family members are invited to participate in all aspects of planning for their child (medical, nutritional, educational, personal appearance, etc.), visit as frequently as possible, maintain phone contact at any time they wish and consult with all professionals serving their child.

CII case management staff aggressively seek contact with children's families. Telephone calls, telegrams, and messenger services are all employed to reassure the family of the child's well-being and to encourage the family members to be involved in their child's life to whatever extent they are able or willing.

Visits are supervised by masters-level case managers. Parents are encouraged to feed, change, dress, and interact with their child. These relaxed, safe circumstances make it possible for staff to suggest alternative methods of discipline, help parents interpret and cope with their child's behavior, build parental confidence, and encourage parents to take an active role in facilitation and support of their child's development. Additionally, these visits bring to light information on the child's genetic, prenatal, birth and early life history.

In addition to the clinical support and active resource and referral services provided to the family while their child is in residence, clinical services are available to families thorugh CII's Family Center, a licensed community mental health center. Treatment includes individual, family and group psychotherapy and parent education. The New Beginnings Program for substance abusing families, a multiagency effort involving CII, Children's Hospital of Los Angeles/University Affiliated Program, and the Exceptional Children's Foundation, offers comprehensive neurological and developmental assessment of children at regular intervals through their first three years; center-based early intervention services designed to enhance children's emotional, social, cognitive, and physical development; parent education offered in parent support groups and "hands-on" training given in the newborn unit itself; individual and family counseling to support parents' efforts to remain drug free and to assist in safe family reunification; and in-home professional support and guidance after children are placed, with either their natural families or in foster homes. The Child Sexual Abuse Treatment Center includes clinical programs for sexual abuse victims, family members, and pre-adolescent offenders. When reunification is being considered, CII's Therapeutic Day Care for ages birth-five and Shared Parenting for ages birth to twelve are available to CII families. In these programs, initiated as a pioneering alternative to foster care for abused children, the child lives at home and is transported to CII or a community home daily; the parent is required to participate in the center or home for at least one day per week. Therapeutic Day Care and Shared Parenting have achieved a substantial reduction in the incidence of parental violence and child injury. Family Day Care for ages birth to four offers a comprehensive child care program to low-income families. All three programs, available for long-term and emergency day care, can provide the much-needed gradual transition most abusing or neglecting families need to be able to function more successfully.

All of CII's programs are augmented by a broad range of auxiliary support services, including transportation to and from treatment programs, child care during treatment sessions, crisis counseling, nutritional guidance, assistance in obtaining social service resources and referral to specialized community agencies and programs. Staffing of all services reflects the bi-linguial, multi-cultural and multi-racial population we serve.

- **Lynn and Chrystal stayed in the center for nine months. Their family visits were always eventful. When mom was sober, her interactions with the children were delightful. Unfortunately, at times marital violence and substance abuse kept her away or brought storm clouds to the center. With much intervention, she gradually was able to self-regulate and contacted CII by phone when things were not going well for her. The twins were thrilled to see her whenever she came and were also very reliant on their relationship with their caregiver when she was unable to come. Mom's ability to participate consistently in parent education, individual and conjoint therapy, and to locate a job were reassuring when the courts decided to allow the twins to go home to their mom. Staff was encouraging and helpful in planning the transition, but due to a sixteen year history of four other children in placement, enrollment in CII Shared Parenting was recommended.**

- **Tynessa was reunited with her father first, as the hospital refused to allow Tynessa to visit her mother there. She was very angry with her father for his absence from her life. She would have nothing to do with him on the first visit. Her father was devastated. For him this was yet one more trauma. Staff reassurance and dad's frequent visits between trips to the hospital to visit her mom and looking for an apartment quickly reduced both daughter and father's discomfort.**

- **Angela's mother presented staff with many complicated dilemmas. Her psychiatric treatment was inconsistent; her alcoholism, florid hallucinations and multiple personalities brought a different visitor each time. Foster placement was decided on by the County of Los Angeles. Unfortunately, after six months of tremendous progress in all areas, Angela was moved with no transition planning.**

- **Tim's mother visited regularly and would end her visit early to be able to have "her own" time with the case manager. The interactions were pleasant and Tim clearly enjoyed their time together. It was necessary to monitor the interaction very closely, as the mother's lack of maturity and extreme neediness meant that she frequently competed with her baby for attention, snacks and once angrily left a birthday party staff had arranged.**

- **Joey's father missed the first seven scheduled visits. He was guilt-ridden that he had not protected his son. Prolonged absences from town and intense jealousy of Joey's mom's new boy friend had blinded him to the life-threatening, extensive abuse his son was suffering. Drug addicted, homeless and hopeless, he still managed to visit with some frequency. Unwilling to seek or receive any services, Joey's dad was a warm, reassuring spectator of Joey's rapidly progressing recovery. Every pound of weight gain, twinkling glance, newly discovered word, or personal skill Joey accomplished was applauded by his dad.**

Leaving CII

The process of leaving CII is a significant time. Planning and transitioning appropriately can aid the child in developing healthy coping mechanisms. The child must have time, support, and respect while facing separation, grief, loss, anxiety, and all that comes with major life changes. The infants and toddlers in the CII Infant and Toddler Therapeutic Shelter Care Program leave when a placement has been made and authorized by dependency court and/or the Los Angeles Department of Children's Services. All terminations are planned and result from the decisions of the court and LA/DCS. Plans include return to family of origin, placement with relatives, foster placement within the

Children's Institute Foster Family Program, or other suitable placement as arranged by LA/DCS.

As more than sixty percent of the CII children needed foster placement and the number of available, appropriate homes in Los Angeles was alarmingly low, CII began a very specialized foster family program to recruit, train and support families for our children. Aggressive recruitment in minority church communities, coupled with training tailored to meet the special needs of our families, has yielded a pool of resources for CII children needing long-term placement. CII's goal is to minimize the number of placements and provide a total continuum of care for all our families.

To facilitate a minimally traumatic transition and a successful placement, the child is prepared for the departure by CII staff and meets, whenever possible, with future family or placement staff to establish a relationship prior to placement. The initial visit will involve a brief discussion of the child's stay at CII, the child's medical progress while at CII, and any relevant information regarding visits with natural parents. Foster parents then visit with the child, who is told in advance about the upcoming visit. The visit will be monitored by CII staff and its length will be determined by the child's comfort level. Photos are taken and caregivers are encouraged to allow the child to talk about the visit in the nursery. When indicated, and when time allows, a subsequent visit is arranged at CII, and the foster parents' children are invited to attend. The foster parents' interactions with the child are encouraged and the monitor remains available to assist the process. The child is then transported to the prospective placement by CII staff well-known by the child.

Whenever possible, the timing of placement is guided by the child's level of comfort. The child is supported through this difficult time by the use of the "life book" and clear, empathetic conversation. A written daily schedule, documentation of all medical considerations, and all personal property accompany the child on the day of placement.

- **Lynn and Chrystal stayed with their mom for several months. CII drivers, day care providers, and therapists worked hard to support the reunification, to no avail. One rainy, cold day, mom presented at the center with two wet, cold, sick children without shelter or money. Mom was planning to "hit the streets" again. She was commended for her efforts to protect the children and counseled to take care of herself. Determined to join a "friend," mom disappeared for several months. The twins were returned to their primary care group, and re-enrolled in early intervention services. They made nice gains and are now visiting with a CII foster family. The visits with mom will continue, probably at the center for the time being. The court is considering permanent placement. The foster family is prepared to make a long-term commitment and to continue reasonable interaction negotiated by CII with mom. Lynn and Chrystal stayed at CII a total of 320 days.**

- **Tynessa was reunited with her mother. Following three days of settling into a new public housing project, the family was ready to receive Tynessa. Her Regional Center Services and relationship with CII pediatrician will remain intact. Tynessa stayed at CII a total of 21 days.**

- **Placed with no transition period, Angela spent the first three days in the county foster home screaming and regressed completely to her "corner" behaviors. The foster mother asked that she be removed, and she was taken to another home. Following many sleepless nights and a psychiatric evaluation deeming Angela "unadoptable" and in need of long-term in-patient treatment at a neuro-psychiatric facility, the foster mother demanded Angela's immediate removal. As there were no available treatment programs, the county social worker asked to readmit Angela to CII. Within a few weeks she felt "back at home." Individual therapy and her spot at the table seemed to soothe Angela's anxiety. An aggressive outreach to the adoptive parent community resulted in the discovery of a family who had vast experience with "special needs" children. Following a three week extensive transition program, Angela showed the staff she was "ready" to move when she left her favorite stuffed animal at her prospective new home and spent that night putting pictures of her new bed and new family in her "life book." More than a year has passed. Angela paid a Christmas visit to CII with her family. Highly verbal, bouncy, successful in school, and extremely healthy, she happily showed her brothers and sisters her "place at the table." Angela stayed at CII 180 days her first stay and 210 days during her final stay.**

- **Tim received corrective eye surgery. His overnight stay in the hospital was very difficult for him when it was time for his caregiver to leave for the evening. His strong attachment was obvious. She stayed until he was asleep. The morning of his discharge, he would allow only his caregiver and his mother to dress him for departure. Tim and his mother are now in a placement for teenage mothers and their babies. Tim stayed at CII for 95 days.**

- **When he would tolerate it, Joey was enrolled in individual therapy. He is now a robust, active preschooler who is the delight of his new CII foster home. His new family recognizes that on-going therapy will probably be a part of Joey's future for some time to come. Joey had stayed at CII for 225 days in all.**

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Transitional Group Homes for Children with HIV: Support for Children, Families and Foster Parents

by

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"You still here, Baby?" Marissa's nurse says, shaking her head. "I thought you'd be long gone."

Marissa should be gone. She has been medically cleared for discharge for three days.

But she's still here. Lying on her back, alone in her hospital crib. Although she is almost two years old, she cannot sit up by herself, or even roll over. Since her stroke, six months ago, the most Marissa can do is to wiggle her way to the foot of her crib. There she lies, tearing at her hair in frustration, waiting for someone to come.

But someone does not come often enough.

Marissa's nurse wishes there was more time in her busy day to spend with her.

Marissa's mother wishes that she could be there to hold Marissa in her arms and comfort her. But Marissa's mother lies in her own bed on the hospital's adult floor and there are few days when she feels well enough to leave it for even a short visit with her daughter.

Marissa and her mother are both infected with HIV—the AIDS virus.

Her mother is in the final stages of her struggle with the disease. But Marissa is doing better, now. Better enough to go home. If only she had a home to go to. If only there was someone well enough to take care of her.

Three days ago, Marissa became a "boarder baby", one who is medically able to go home, but remains hospitalized only because she has no place to go. Unfortunately, her situation is not an isolated one. It is played out in variation, over and over again in the hospitals of our inner cities.

Although so called "boarder babies" have long been with us, the rapid rise in the number of children infected with HIV since 1981 has increased their ranks enormously. The Centers for Disease Control (CDC) projects that by 1991, there will be 10,000-20,000 children infected with HIV. Approximately 78% of the current number of children infected with the virus acquired the disease from their mothers via perinatal transmission. This percentage is expected to climb higher as the number of newly diagnosed children who were infected via transfusion of contaminated blood products continues to decrease (effective screening of blood and blood products has been in place since 1985). To date, educational programs aimed at reducing risk factors, such as shared needles, sexual contact with infected persons, and becoming pregnant while infected, have not had the desired effect in reducing newly diagnosed cases of HIV/AIDS in the IV drug abusing community. While the effort to reach this population through education must be vigorously pursued, it is a formidable task.

In this article we will describe the unique circumstances of families with HIV that make care outside the extended family a necessity for many infected children. The challenge of finding quality foster care for these children and the role of a small group residence in supporting children, biological families, and new foster parents during the search for, and transition to, permanent individual placement, will also be addressed.

Where are the families?

Why do HIV infected children, like Marissa, have no home to go to? Where are the parents, extended families, and foster parents for children infected with this disease?

These questions can be answered, at least in part, by looking at the unique circumstances of families with HIV, the societal reaction of fear to this diagnosis, and the difficulty in placing chronically ill children in an already over-loaded foster care system. Most "boarder babies", like Marissa, are children who have contracted HIV perinatally from their infected mothers, many of whom have a history of intravenous drug abuse or sexual contact with an intravenous drug user or bisexual man. Many of these mothers are unaware that they themselves are infected or that their fetus was at risk during pregnancy. Drug abuse, alone, is a disabling factor for a family, often making it impossible for parents to care for a child, even when the child is well. When the HIV infection for one or both parents and child (or children) is added, the situation may become untenable. This is especially true if the parent(s) are themselves incapacitated by either their own illness or the effects of drug abuse. Because of its relationship to intravenous drug abuse, pediatric HIV infection tends to be a disease of poverty, with all its attending stresses of economic deprivation and despair. These unfortunate factors all contribute to the biological family's inability to care for its child with HIV and increase the need for foster care.

Although many extended family members have come forward to support and care for both a parent and child who are ill with HIV, others have condemned and rejected those who are infected. Some have provided emotional support but have been unable to care for ailing family members due to the limitations of their

AIDS is a condition in which the body's defense system, which fights infections and some cancers, is destroyed. It is caused by a virus called *H*uman *I*mmunodeficiency *V*irus—HIV. Though the virus affects people differently, there are basically three stages of infection.

Asymptomatic infection. An adult or child who has been exposed to the virus and tests "antibody positive" may have no symptoms or signs of the disease. Many people at this stage do not know they are infected, but they can transmit the disease. It is estimated that there are one to two million people in the U.S. who are asymptomatically infected with HIV.

Symptomatic or AIDS Related Complex. People at this stage show some signs of immune deficiency. They may begin to show general symptoms such as persistent swollen lymph nodes, chronic colds, ear infections, and flu-like symptoms. Most people at this stage go on to develop AIDS.

Full blown AIDS—Acquired *I*mmune *D*eficiency. People with AIDS are infected with HIV and may have symptoms similar to ARC patients but have, in addition, certain infections or cancers that do not normally occur in people with healthy immune systems. These are called opportunistic infections. It is these opportunistic infections, along with a positive antibody to HIV, that make the diagnosis of AIDS. There are over 70,000 people diagnosed with AIDS in the U.S. to date. Over 1,100 of these cases are in children under age five.

own circumstances. A third group are not even aware of the existence of HIV in their family at all. The decision to tell family members about the infection is a difficult one, which often includes admitting to secret aspects of one's life (such as IV drug use, sexual relations, etc.). Many parents would rather lose their opportunity for support than deal with the presumed consequences of revelation. In a survey of 45 families at Children's Hospital of New Jersey at the time of the child's death, 60% of the parents had not told any extended family members the child's diagnosis.

The search for foster homes

These realities greatly reduce the potential for an HIV infected child to find a home with extended family members, usually the first possibility explored by child welfare workers. But looking beyond the extended family for quality foster home placement often proves to be an even greater challenge because children who are HIV positive are particularly difficult to place. Despite energetic attempts to educate the public concerning the transmission and prevention of HIV/AIDS, widespread fear of contracting the disease persists. Ignorance and prejudice are still very much associated with HIV infection, and a potential foster family may be faced with ostracism by community or family members as a result of its decision to care for a child infected with the virus. Previously trusted sources of family support may disappear at a time when they are most needed. This very real possibility may prevent many would-be caregivers from taking on the responsibility of foster care for an HIV positive child. Most discouraging may be the day in, day out realities of caring for a child infected with HIV, which are, at least potentially, very difficult ones.

Children with HIV infection vary widely in the severity of their symptoms. Some, although HIV positive at birth, are merely carrying antibodies passed on from their mother and convert to negative status before the age of two. In fact, these children are never truly infected with the virus. Others are ostensibly "well" for a long period of time, while still others may have intermittent bouts with HIV related illnesses. A smaller number develop quite severe symptoms as early as six months after birth and continue on a downward course to full blown AIDS and death. Regardless of the severity of their symptoms, however, all children infected with HIV require ongoing medical care, which may be as infrequent as a once-a-month clinic visit or involve chronic or long-term hospitalization. Although there is no direct financial cost to the foster family for such care (the child is a ward of the state and covered by Medicaid), the time, emotional and physical resources that the family expends in such care can be depleting.

In addition to the medical problems that are expected in children with HIV, there are often neurodevelopmental problems about which the general public is much less aware. In fact, central nervous system involvement in children congenitally infected with HIV is present in up to 90% of the cases. These abnormalities include developmental delay and deceleration or loss of previously attained milestones, such as walking or talking. As is true with other HIV related symptoms, manifestations of neurodevelopmental involvement can range from mild to severe. The onset of these symptoms is usually associated with other signs of the virus and as the child becomes more ill, his neurodevelopment tends to become more impaired. Changes in muscle tone or spasticity are also often seen, creating cerebral palsy type effects in addition to signs of cognitive deficit. In some cases, blindness or deafness has occurred in the disease's final stage. These neurodevelopmental problems are believed to be the result of direct invasion of the central nervous system by organisms of opportunistic infection or by the AIDS virus itself. Symptoms may also be exacerbated by psychosocial factors, such as chronic illness and hospitalization, poor nutrition and environmental deprivation. A prospective foster parent must, therefore, be prepared to deal with a child who may become increasingly handicapped, as well as sick, over time.

As grim as these frightening realities are, it may still be possible to find more suitably qualified individuals to take on this responsibility if the outcome of caring for a child infected with HIV were more hopeful. But the current mortality rate for these children is very high. Various studies presently available indicate that 30% of the children with congenital, symptomatic HIV infection will have died by 2 years of age and that the median age of survival is 47 months. Early and aggressive medical intervention and ongoing support, however, appear to be prolonging not only the lives but the quality of life, for children infected with HIV. Some children with congenital infection have now reached 6 years of age and it is difficult to project how advances in medical care will modify the course for the future. Nevertheless, foster families of HIV infected children today must face the probability of their child's illness and eventual death.

All these factors make the thought of becoming a foster parent to an HIV infected child a daunting one. The stresses and problems are enormous and yet the need for quality homes for these children is even greater. In the state of New Jersey alone, one third of those children who are HIV positive are under the supervision of the Division of Youth and Family Services (DYFS), the state child welfare agency. Of these 211 children, 88 are in some type of foster care or are hospital inpatients. For any child in foster care, the average length of stay in one home is 27.7 months and 54% of the children are in more than one foster home in just over two years' time.* Although separate statistics for HIV positive children are not available, one can only assume that given the stresses inherent in caring for such children, their situation regarding number of foster placements and length of stay may be worse.

The challenge presented by the rise in numbers of children infected with HIV who need foster care is one not welcomed by already overburdened social service agencies. But it is one that does not promise to diminish and, in fact, is only expected to become greater.

Since the complex problems associated with finding and maintaining quality foster homes for HIV/AIDS children refuse to go away, it is necessary for child welfare agencies to develop aggressive and innovative recruitment strategies, educational programs for both workers and potential foster families and continuing support for the family once placement for a child is secured. This is a tall order for agencies, who like their health care counterparts, have been overwhelmed by the pediatric AIDS crisis.

It is the enormity of the crisis itself, however, which has been the impetus to the creation of some mitigators, if not actual solutions, to this problem. The provision of financial incentives to foster parents of an HIV infected child, which increase in relation to the progression of the child's symptoms, has served to widen the pool of families able to provide a home for an HIV infected child. In addition, the usually conservative foster care system has become more willing to consider non-traditional candidates for foster parenting of HIV/AIDS children, such as single men and women and even some openly gay couples. For some foster families, especially those who can provide a home for more than one HIV infected child, supports, such as a social service agency sponsored homemaker or home health aide, have been provided. In spite of these efforts, however, there are still HIV infected children who are without homes. The number of appropriate foster placements for children simply cannot keep pace with the numbers of children who need care.

Transitional care facilities

In some cities, where the number of such children is particularly high, transitional care facilities have opened in order to provide a stable environment as an alternative for children waiting in hospitals or shifting from one foster home to another. They may also provide foster care for biological families who are temporarily unable to care for their children because of illness, homelessness or other extraordinary circumstances.

St. Clare's Home for Children, in Elizabeth, New Jersey is one such place. It is a small group residence, whose purpose is to provide a home-like, transitional foster care environment for children whose more permanent individual placement is being sought. St. Clare's Home is sponsored by the AIDS Resource Foundation for Children and is primarily funded by the New Jersey Division of Youth and Family Services (DYFS) and Medicaid. The underlying philosophy of the home is that children belong within the family structure and the ultimate goal for each child is placement in a loving and stable home. The transitional nature of St. Clare's enables more children, like Marissa, to leave the hospital and benefit from care that is both nurturing and stimulating. St. Clare's has been home to Marissa and 15 other children in similarly bleak circumstances since its opening in May, 1987. Children who are HIV positive and are eligible for foster placement are referred by DYFS to St. Clare's, where they remain while the child welfare agency recruits foster parents and completes procedures for placement or until the child is able to return to the biological parent. Children at St. Clare's have ranged in age from six weeks to five years old and have lived at the home for as short a period as one month to as long as thirteen months.

Approved to house five children at a time, ranging in age from birth to six, St. Clare's is staffed by ten child health care workers, a housekeeper, a house manager who is trained in child development, and a nurse. A social worker is also on staff to provide expertise in dealing with psychosocial issues. All staff and volunteers receive pre-service and ongoing training and support. Although it is a group setting, St. Clare's caregivers are trained and encouraged to relate to each child as a unique individual. Every effort is made to respond to the child's needs and to accommodate to differences in temperament and style. A child has his/her own primary caregiver on each shift. This person remains a constant for the child, affording the opportunity for the development of emotional attach-

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*New Jersey DYFS monthly statistics report, October, 1988.

ment and security. House activities, toys, play equipment, daily schedules and routine caregiving are all aimed at facilitating and encouraging social-emotional, physical, cognitive and language development.

Since most children born with HIV are at risk for or show developmental delays, the children at St. Clare's receive supportive services from the Early Intervention Program of Children's Hospital of New Jersey. Each child's developmental status is assessed by the Early Intervention Team and an Individualized Educational Program is created with input from the child's caregivers. The children attend a center-based Early Intervention Program session weekly, accompanied by their caregivers, who are instrumental in carrying out developmental suggestions on a day-to-day basis. Those children requiring additional therapy attend individual sessions with a physical or occupational therapist. Children who have been lucky enough to find a place at St. Clare's have thrived in its child-centered environment.

When Marissa first moved from the hospital to St. Clare's, her affect was flat, she made no sound other than crying, and her only movement was to wiggle a bit while lying on her back. After only several days at St. Clare's, Marissa was smiling and pointing to indicate her needs. Over the next few months, she began to sit unassisted, actively play with toys and crawl on her belly.

Marissa developed an especially close bond with Sharon, one of her primary caregivers, who began to use signing to communicate with her. Within a few months, Marissa was not only responding to Sharon's signs but had begun to sign in return. Marissa, at present, understands more than 30 signs and has an expressive repertoire of 20 signs. She has recently begun to use verbal approximations for several words as well.

Although Marissa's progress is in some part attributable to her improved health status, since she as been taking AZT (two months after her arrival at St. Clare's) the excellence and constancy of her overall care must surely bear a large part of the responsibility for the improved quality of her life and the great gains she has made.

Recognition of the importance of continuity in the child's realtionships is also apparent in the manner in which St. Clare's conducts transition procedures from its home to the child's more permanent foster placement. For most children who have been at St. Clare's, transition to a foster family has occurred between the ages of 12-20 months of age, a time when a sense of attachment and emotional security is developmentally critical. The transitional policy enacted at St. Clare's attempts to provide for the child' timely and appropriate transition, as well as for the education and training of the foster parent. Training and support of prospective foster parents is done by both professional and childcare staff at St. Clare's and seeks to familiarize the foster parent with the child's individual needs and to encourage the bonding process between the new foster parent and the child. This process takes place over a period of time, and includes the provision of factual information to the foster parent about HIV/AIDS transmission and infection control, as well as specific advice concerning the child's care and needs. The foster parent spends time with the child, beginning with visits at St. Clare's and progressing gradually to the child's day-long and then overnight stays at the home of the prospective foster parent.

Throughout the transition period, the St. Clare's social worker periodically meets with the foster parent and through frequent phone contact monitors progress and is available to discuss the foster parent's needs and concerns. Follow-up visits to the foster home, as well as regular phone calls with the foster parent, help to ensure that the placement is going well. The foster parent is also encouraged to participate in all the events and program sponsored by AIDS Resource Foundation for Children and St. Clare's (family support group, celebrations, outings, etc.). This helps foster parents to feel that there is ongoing support available to them, which may alleviate feelings of stress and isolation. It also allows the child to continue important relationships with previous caregivers.

In addition, Early Intervention Program services for St. Clare's children are continued after foster home placement. This is another way in which constancy in care relationships and service are maintained. If the child moves out of the Newark area, services in another early intervention program, closer to the child's home are sought. Although until recently few early intervention programs have been willing to serve HIV/AIDS chidlren, this pattern is beginning to change as the need increases and education dispels fear.

Although these procedures provide as optimal a transition as possible, most children still have difficulty when the change in homes and caregivers finally occurs. Unfortunately, the child may change homes more than once, since the concept of foster care implies temporary placement.

* St. Clare's Home and others like it (a second St. Clare's in Jersey City, New Jersey, and similar facilities either in operation or the planning stages in New York, Boston, New Orleans, California and Texas) are ambitious attempts to meet at least the foster care needs of HIV/AIDS children, especially those of the so-called "boarder babies", like Marissa. Although such homes are expensive to create and maintain (St. Clare's Home, for example, has daily operating costs of approximately $260 per child) when compared to the costs of unnecessary hospitalization, they are a bargain.

According to a study conducted at Harlem Hospital in New York City, 37 infants and children with AIDS, ARC or HIV positive status, treated at the hospital between 1981 and 1987, incurred costs of approximately $3.4 million for inpatient care alone. These patients had 6,035 inpatient days with a per diem cost range of $300-$2,400 a day. The same study reports that 30% of all hospital days and 20% of the costs for these children could have been avoided if they had been placed in out-of-hospital facilities. Although the financial benefits of alternatives to hospital care can be documented and are impressive by themselves, the far greater gains may be in the psychosocial and developmental advantages to the children.

Transitional group homes for HIV/AIDS children are presently only operating on a small scale, but their ability to provide individualized, quality care and to support the child and foster parent through transition and beyond may be the model for making foster care for HIV infected children work. Enhancing the possibility that the child's long-term placement in a foster family will be maintained is, in the end, far less costly to the state and far better for the child than multiple placements or a return to "boarder baby" status.

Other alternatives must be further explored in the attempt to meet foster care needs for HIV/AIDS children. Perhaps the first is a more zealous effort to keep the child within his or her biological family for as long as possible. Support and practical assistance, similar to that provided to foster families of HIV/AIDS children, could do much to enhance the biological family's ability to care for an infected child and may defer or eliminate the need for out-of-home placement. Group homes, serving the family as a unit or mother/child dyads may also prove to be effective options in reducing the numbers of children requiring foster care.

Permanent residential care in a small, group setting must also be considered to ensure stability for HIV/AIDS children.

The role of the hospice in regard to children with AIDS also needs to be developed as an alternative to hospitalization for the child in the end stages of the disease. Hospice support before and in the months following the child's death could be of great assistance to both biological and foster families and may enable some to continue caring for a child, at home, when they otherwise could not.

Will aggressive education and recruitment, the willingness to consider non-traditional families (such as single parents or gay couples) and financial incentives be enough to stem the ever-increasing need for foster care for HIV/AIDS children?

Will practical assistance to biological and foster families, such as the provision of home health aides, respite care and emotional supports, such as parent groups and hospice, reverse the escalating numbers of HIV infected children in need of homes?

Can transitional or other group residences be created quickly enough and maintained with sufficient quality to ease the "boarder baby" crisis for HIV/AIDS children?

There are no pat answers to these questions, no easy solutions to this complex problem that only threatens to worsen. One can only glimpse a bit of hope in a visit to a home, such as St. Clare's, where Marissa, who once languished alone in her hospital crib, now smiles from someone's lap and waves "hello".

Post script

During the months that Marissa lived at St. Clare's, her mother became increasingly ill. She died of complications of AIDS last summer, shortly after a final visit with her daughter.

Marissa's favorite caregiver, Sharon, left St. Clare's five months ago for another position but continues to return several nights a week to put Marissa to bed.

Sharon has been approved to become Marissa's foster mother and Marissa is now completing a smooth transition to her new home. Marissa continues on AZT therapy and is doing well.

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Call for Papers

Infant Conference '89: Moving from Research to Practice— Directions for Implementing Infant Services in the '90s invites poster proposals for its **May 11-13, 1989** conference in Los Angeles. **Submissions must be postmarked by March 25, 1989**. Posters may address a broad spectrum of infancy-related topics. For information contact Infant Conference '89, c/o UAP-CHLA, P.O. Box 54700, Los Angeles, CA 90054, tel: (213) 669-2300 or (213) 226-3454.

The Literature Prize Committee of the **Margaret S. Mahler Psychiatric Research Foundation** is accepting papers to be considered for the 1989 annual prize of $750. Papers should deal with clinical, theoretical or research issues specifically related to Mahler's concepts of separation-individuation in child development. Six copies of papers submitted must be received by **December 31, 1989** by Dr. Marjorie Harley, Chairperson, Margaret S. Mahler Literature Prize Committee, 201 St. Martens Road, Baltimore, Maryland 21218.

Forming Human Connections in Shelters for Homeless Women and Children

by
Nancy A. Boxill, Ph.D.
Women in Crisis
Y.W.C.A. of Greater Atlanta
and
Board of Commissioners
Fulton County, Georgia

A new kind of public institution is appearing in our communities—the "shelter for homeless women and children." This kind of societal response to the presence of homeless families on our streets and in our mind's eye reflects dramatic changes in American society, and in the way our nation cares for and supports families. My own experiences with homeless women and their infants in Atlanta's public shelters has led me to revisit the concept of bonding and to wonder about the kinds of human connections that can be formed in these settings.

For this conversation, then, allow me to reconceptualize **bonding** as the primary **human connection** which provides security, safety and the beginnings of self-determination, occurring within a specific experiential and environmental context. The work of Erikson (1963) and Rivlin (1986) serves as a backdrop for my thinking. Erikson instructs that the journey of human growth and development is both natural and mutual. In other words, growth is a process with an energy and direction of its own. While the process is certainly subject to the influence of people and circumstances, the fact that we *will* each grow in spite of or in cooperation with circumstances, is incontrovertible. Erikson further instructs that the growth process is a *mutual* process. What is growth for the child is simultaneously growth for the mother or primary caretaker; the task/goal of mutual trust for the infant is simultaneously intimacy and generativity for the parent.

Phenomenology and environmental psychology, particularly the work of Rivlin, further describe the framework for my conversation by positing that in order to understand human experience we must understand the context in which an experience occurs. So to talk about human connections which occur in the context of a new kind of public institution, **shelters for homeless women and children,** I begin with a description of the setting or the circumstance in which bonding occurs for mother and child.

Shelters for homeless women and children in Atlanta are typically large open spaces in which many families live out their family life. These large spaces become, in effect, institutional settings in which there is no private time, no private place, no private space for any family interaction. Imagine having to carry out all of your family interaction, all of your family business, within full public view of others. Every aspect and nuance of the mother/child relationship occurs under and is affected by its public scrutiny. From waking to waking, mothers and their children live in shared spaces. Family units which have previously enjoyed the freedom to express love, caring, frustration, anger and all manner of other emotions in their own homes are now forced to express their feelings in communal settings, subject themselves to prevailing shelter rules for communal living, stifle their strongest and deepest feelings, expose their personal style of "mothering" to strangers, capitulate to peer pressure, and catch glimpses of who they appear to be in the eyes of onlookers.

NANCY P. ALEXANDER

Daily living in homeless shelters raises two questions for me about the nature and process of the human connection/bonding. First, what is the effect of the loss of what Leanne Rivlin (1986) calls "personal space" on the human connection? Second, how does the context of shelter life affect the course of establishing human connections? To date we have no longitudinal studies which provide insight into the first question. We do have anecdotal and participant/observation data gathered in Atlanta which provide both beginning questions and beginning answers to these and other questions.

Loss of privacy

Not long ago I sat with a young mother who was living in the YWCA Shelter in Atlanta. While we were having dinner she cradled her two day old infant in her arms. This mother had delivered her baby at the local public hospital. Having nowhere else to go, she and her newborn came to live at the shelter. While she ate, I held her infant. The infant began to cry when passed from the mother to me. I stood up and walked around our dining area, cradling the baby close to my chest and whispering to her, "It is going to be all right. This is a difficult way to begin your life, but it is not always going to be like this." I repeated this over and over in her ear, returning her to her mother after about twenty minutes . I said those same words to the mother as I left them in their family unit and walked away.

The above anecdote speaks so clearly about families in our shelters. For them, the formation of a human connection must occur, if it can, without the benefit of privacy. Living in a public place twenty-four hours a day, every day of one's life, seems to mean that every special moment of mother/child interaction becomes a moment that is shared and/or interrupted by strangers. The course of establishing the early human connection between infant and mother is not allowed to evolve on its own. The circumstances of shelter living, including the intrusion of outsiders, often disrupts what is believed to be a natural and necessary process.

The dyad's need for privacy is so strong that it often appears to the observer as actual physical rejection of outsiders. On a recent visit to a shelter for homeless women and children, I observed a mother with her two children (both under two years of age) lying on a single bed totally submerged under sheets that had been fashioned into a make-shift tent. There was a tiny space through which air and noise and the eyes of strangers could intrude. Each time a stranger walked by, the mother would close that tiny open space even more. As I stood near this bed which had become a tent, I heard the mother talking to her children about their life and what was happening to them. This creative mother constructed a barrier which, for a moment at least, could exclude the peering view, judgments and interruptions of passing and unrelated strangers. She had carved out the space necessary to ensure a private moment during which she could connect with her children.

It is important to remember that whatever private moments occur between family members in open public shelters are extremely limited. Well-meaning shelter staff and volunteers often inadvertantly interrupt and/or intrude, inserting themselves into the private moments that are a necessary element for healthy growth and development.

What happens when what would normally be a private moment becomes a publicly regulated moment or, worse yet, when the private moment does not occur? How does such a circumstance influence the human connection? How does such a circumstance influence self-definition? My beginning answers to these questions have emerged from the families that I know and have worked with as a participant/observer. There is much I am only beginning to understand; however, I am certain that the influence of shelter living on the process of establishing human connections is not good. Mothers of newborns routinely have their infants handled, fed and otherwise cared for in a public arena and in a shared fashion with other adults, who are often strangers rather than trusted supporters of the new mother. For the mother to deny these strangers access to her family life, access to her children, is to take the risk of being asked to leave the public shelter because she is not "cooperative," because she is not "friendly." The mother is faced with a choice: cooperating or having no place at all to live.

Mothers of newborns in shelters often appear to be confused and sad, and they talk about their confusion in a very striking way. They speak of not being able to develop their own patterns or style of relationships with their children because of the peculiarity of the circumstance. Infants are often irritable and startled by changes in their position or in caregivers. Toddlers frequently alternate between clinging to their mothers and clinging to other adults, never appearing secure about the next unfolding moment. But clinging is not bonding: clinging is only a physical connection, not a full human connection.

Self-definition

How does the experience of life in a shelter influence self-definition? Infants and most toddlers cannot tell us what they feel. The mothers can, and do. The comments of one young mother reveal expressions of strong love and equally strong expressions of inadequacy. In tones of desperation and confusion, she told me "I'm doing the best I can because my kids are all that I got, but my God, it isn't good enough." I told this young mother that I didn't know what "good enough" meant to her and that I believed that what was happening to her now was not what she wanted. We began a thirty minute discussion about what she was already doing to establish her human connection with her children and other things that she might be able to do, even in her difficult circumstances. I left that exchange feeling as though I had supported this mother's intentions and affirmed her desires. I wanted to prevent the "unraveling of the mother-role" (Boxill and Beaty 1986) which I believe occurs in shelter living. I left that mother hoping against hope that the events of the next day would not push her through the incredibly tenuous weave of the safety net our encounter had begun to create.

The foregoing discussion has been entirely focused on mothers and children. This is due in part, to the limitations of my observation and experience. My experience however, has not been limited by choice but rather by the pattern of existing shelter occupancy. The pattern of public and private shelters is to restrict occupancy to either males or females. The overwhelming majority of shelters (nationwide) do not or cannot accommodate two parent families. Fathers are therefore forced to be absent from their wives and children during a stressful time. The forced absences of a significant

family member (father) further reduce opportunities for natural human connections at a time when emotional support and physical nearness would be helpful, if not necessary. This circumstance is deserving of attention by researchers.

The behavior of the children and the comments of their mothers have convinced me that the arduous challenge of establishing a human connection to one's own family member in a shelter setting places self-definition at best in doubt, at worst, in jeopardy. But the worst case can be avoided if service providers, researchers and professionals will re-think our approach to working with this population. My experience suggests that shelter programs can provide limited support to families even in difficult circumstances. A few such suggestions were discussed in a previous paper and are summarized here. Publicly supported day and night shelters would do well to reassess and strengthen the opportunities available for families to have private *time* if not *space*. Any effort to afford a family member living in public a moment of privacy will enhance opportunities to restore order to their relationships. Wherever practical or possible, volunteers and professionals should encourage the creation of private moments in even the most public places. The use of volunteers must be reassessed. Where volunteers are unintentionally replacing or usurping mothering roles, this should be corrected and/or minimized. A restructuring of meal, recreation and clean-up times can create opportunities for human connections to be emphasized naturally. (Boxill, Beaty, 1986)

Finally, thorough and careful thought should be given to any support or ancillary service/program designed exclusively for "homeless" children. Separating out these children by circumstance suggests that they are "at risk" and have special unmet needs which, through direct, planned and professional programmatic intervention can be "fixed." I believe that it is society, not the children, who are "at risk." We are at risk of creating special programs and categories of service for an identified special population which ensure the perpetuation and institutionalization of a *program*, and more important a *population*. Wouldn't society be better served by securing and/or constructing housing rather than securing services for recipients and reconstructing people?

I hope that our society never comes to know the long-term effect of shelter living on bonding/human connection. I hope that we as a society never know or notice the impact of shelter living on self-definition. I am convinced that my own interaction should be guided by Erikson's strong statement that human growth and development is a natural process. He cautions those of us who choose to intervene and participate in the growth process to be careful of the way in which we intervene. I hope that all of us who interact with homeless families come to understand and appreciate the ways in which we can be helpful and supportive in strengthening the human connections between mothers and children. If we can use *naturalness* as a guide for the ways in which we attempt helpful intervention, perhaps we will eliminate some of our well-intentioned but intrusive window shopping in the lives of others. More importantly, perhaps we will insist on more sensitive approaches for those who are struggling to achieve natural relationships in unnatural settings. The strength of human connection sustains each of us. We cannot afford simply to study its absence, disruption or distortion. We must speak and act for its preservation.

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National Center Notes

by Eleanor S. Szanton

"The beginning is the most important part of any living thing."

Socrates

The National Center is pleased to announce several additions to our leadership:

To our Board of Directors

- **Robert A. Nover, M.D.,** a member of the group that founded NCCIP and its original Secretary/Treasurer, has rejoined our Board of Directors after a leave of absence. Dr. Nover is Associate Clinical Professor of Psychiatry and Child Health and Development at George Washington University School of Medicine. He is also Psychiatric Consultant to Ivymount School for Exceptional Infants and Children and in the private practice of psychoanalysis. He was formerly Research Psychiatrist at the innovative Clinical Infant Development Program developed in 1977 under the auspices of the U.S. Department of Health and Human Services' National Institute of Mental Health.

To our staff

- **Patti Biro, M.Ed.** joins NCCIP's staff as Program Associate for State Technical Assistance. Ms. Biro holds degrees in Speech Pathology/Audiology and Deaf Education. She was formerly Coordinator of Washington State's High Priority Infant Tracking Program, located at the University of Washington's Child Development and Mental Retardation Center in Seattle. She has consulted extensively with other states attempting to develop systems of tracking and serving infants and toddlers who have special needs and who are at risk. She will expand and enhance the activities of NCCIP as it works with states to develop truly comprehensive services for these populations and for their families.

- **David F. Chavkin, J.D.,** will create the newly fulltime position of Senior Program Associate for Public Policy/Public Education. Mr. Chavkin is an attorney who has worked extensively in the areas of health law, disability law and civil rights. He is former director of the Maryland Disability Law Center. He will lead and coordinate all of NCCIP's activities at the federal level designed to increase the understanding of the legislative and the executive branches of government, as well as other child advocates, of the importance of public policies on behalf of America's youngest children and their families.

- **Linda Eggbeer, M.Ed.,** has joined NCCIP's staff as Assistant Director of NCCIP's Training Approaches for Skills and Knowledge (TASK) project. This three-year project is working to develop consensus recommendations concerning the training of infancy personnel, building on the perspectives of consumers, educational institutions, professional organizations and government policymakers. The project is developing issues papers and a forum for discussion of common concerns. Ms. Eggbeer has an extensive background in child development as well as in training programs for child care providers and health professionals.

We warmly welcome these individuals as we work together in recognition of Socrates' wisdom.

Letter to the Editors

I read the September, 1988 issue of *Zero to Three* with great interest. The material presented concerning utilizing motor activities for adaptive coping (Williamson), sensory-affective interactions to strengthen parent-infant communication (Bernstein) and fostering social/emotional growth with infants with disabilities (Greenspan) strongly connects to the work being done by movement therapists where I work.

At our center, movement therapists focus on motor activities and sensory-affective interactions to foster social/emotional growth with infants and young children who are at risk for developmental problems—children who may not have the "sending" power needed to make their signs and signals understood as efforts to communicate and/or achieve need satisfaction. Knowledge of psychodynamic and developmental theory coupled with training in movement observation and analysis provide movement therapists with unique skills enabling them to pick up non-verbal cues and build them into object-related interactions.

The movement therapist acts as a facilitator, helping caregivers read and sensitively respond to their children's spontaneously offered cues. Caregivers are also taught to be aware of the impact of their own body movements, affect and tone of voice on their children.

The successful translation of non-verbal language provides the medium through which generalized interactional relationship patterns can develop.

Movement therapy has become a unique and integral part of our program. Movement sessions focus on the spontaneous interactions between parent and child. The material for therapeutic intervention lies in what is happening between the child and parent at any particular moment. The child and primary caregiver are treated together, with other family members sometimes included. Adult-child interactions display a wide variety of healthy and conflicted relationship patterns.

Sessions emphasize the family context of child development and the need to foster a child's growth as a person, no matter how severe the impairment. During sessions, the caregiver and child are given the opportunity to "be together" without focusing on "fixing" the handicap. Treatment is aimed at enhancing sensory-motor strengths rather than alleviating deficits. The therapist makes use of the child's intact perceptual biological strengths to permit meaningful contact with the environment.

Adults relinquish control over child behavior in favor of attending to spontaneous activity and the healthier aspects of functioning. Sessions focus on the need to support child-initiated activity in order to facilitate changes in child-caregiver interactions. Spontaneous cues are built into object-related interactions within the frame of lines of development and phase appropriate play.

Therapists focus on non-verbal parameters needed to develop the synchrony for the increased attention and mutual attunement necessary for secure attachment: they focus on the small doses of dysynchronous experiences needed to promote differentiation. Non-verbal parameters that are noted include the child and parent use of personal space, direction of gaze, focus, body attitude, flexibility, molding, exploratory/blocking behaviors, contact seeking/avoiding patterns, rhythmic interaction and the degree of match or mismatch of movement qualities.

The rich language of movement interaction provides insight into conflicted and conflict-free spheres of relationship patterns. The movement therapist, specially trained to observe changes in body movement, flow, shape, rhythm and dynamics can fully utilize the non-verbal system of communication. S/he is particularly able to aid the parent in translating non-verbal cues and building them into object-related interactions.

Sensitizing caregivers to their child's non-verbal communications and the need to accommodate their own non-verbal behaviors to foster their child's growth as a person has helped develop positive parent/child relationships.

If you are interested in further information, you may contact the American Dance Therapy Association, 2000 Century Plaza, Columbia, Maryland 21044 and/or write to me: Bette Blau, M.A., A.D.T.R.
Director of Movement Therapy Services
Little Village School
Bayberry Avenue
Garden City, NY 11530

For Your Information

The **Beach Center on Families and Disability** at the **University of Kansas** is conducting a national survey, funded by the National Institute of Disability and Rehabilitation Research, of parent support groups that use a parent to parent approach. Information from the survey will be used in the development of a national Parent to Parent Network that can help programs learn from each other and assist new groups with start-up tasks. Programs that use the parent to parent approach are encouraged to call or send the name of a program representative by **March 31, 1989** to Betsy Santelli or Ann Turnbull, Parent to Parent National Survey Project, Beach Center on Families and Disability, Bureau of Child Research, 4138 Haworth Hall, University of Kansas, Lawrence, KS 66045-2330, tel: (913) 864-4950.

PARENT ACTION is a newly-formed division of the Family Research Coalition that will use public education, community outreach, public policy initiatives and media relations to help parents constructively address their parenting needs. T. Berry Brazelton, Susan DiConcini, and Stevie Wonder are honorary co-chairs of the organization, which is modeled on the American Association of Retired Persons. PARENT ACTION is based in Washington, D.C. and Chicago. The Washington office, directed by Mary Conklin, former staff to Senator Reigle of Michigan, is responsible for government relations, and the Chicago office will handle the development of education programs and membership services. PARENT ACTION is supported through annual membership dues of $5, public and private foundation support, and private donations. For a free copy of PARENT ACTION'S brochure, write or call Mary Conklin, Government Affairs Director, PARENT ACTION, 1155 21st Street, N.W., Suite 1000, Washington, D.C. 20036, tel: (202) 835-2016.

The **International Society for Infant Studies** was formed in April, 1988, an outgrowth of the International Conference on Infant Studies. Officers are Nathan A. Fox, President; Marian Sigman, Past President; Anita M. Sostek, Treasurer; Lorraine McCune, Secretary; and Gerald Turkewitz, President Elect. Peter Gorski, Susan Rose, Tiffany Field, Peter Vietze and George Butterworth serve on the Executive Committee. *Infant Behavior and Development* is now the official journal of the Society and a benefit of membership. For membership information, write to Nathan A. Fox, President, ISIS, Institute for Child Study, University of Maryland, College Park, Maryland 20742.

The **Merrill-Palmer Institute, Wayne State University,** in cooperation with faculties of psychology, social work, education and nursing at Wayne State University, has announced a new graduate certificate program in infant mental health. The program includes academic coursework, assessment techniques and strategies for intervention, clinical case supervision, and interdisciplinary colloquia. The Infant Mental Health Certificate will be awarded upon completion of required coursework, field placement and supervision in partial fulfillment of a master's degree program or in post-master's degree study. For additional information, contact Dr. Eli Saltz, The Merrill-Palmer Institute, Wayne State University, 71-A East Ferry, Detroit, MI 48202, tel: (313) 577-5244.

Publications

Evaluating Family Programs (1988)—Heather B. Weiss and Francine H. Jacobs, editors (Aldine de Gruyter, 200 Saw Mill River Road, Hawthorne, NY 10532) $59.95, cloth; $26.95, paper.

This 550-page volume grew out of the Harvard Family Research Project, which was established in 1983 to collect, review, synthesize and disseminate information about the effectiveness and evaluation of diverse grass-roots programs designed to provide support and education to families with young children. The 22 commissioned essays included here come from program evaluators and researchers. The first section of the book outlines a broad conception of evaluation that moves beyond child outcomes to assess a range of effects and causal processes. The second section reviews and recommends specific measures to assess changes in the child, parent-child interaction, the parent, the family system, family stress and coping, and social support. The third section includes evaluations of 10 different programs, including David Olds' Prenatal/Early Infancy Project, AVANCE, MELD, Child Survival/Fair Start, the Child Welfare League's Adolescent Parents Projects, and the Family, Infant and Preschool Program. A final group of essays explores cost analysis, the technique of meta-analysis, and the implications of racial and ethnic diversity for program design and evaluation.

Ecological Research with Children and Families: From Concepts to Methodology (1988)—Alan R. Pence, editor (Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027) $32.95, cloth; $18.95, paper.

In the 1970's, Urie Bonfenbrenner proposed the necessity of an "ecological frame of reference" for research on human development, because developmental processes taking place in the immediate settings in which human beings live are profoundly affected by conditions and events in the broader contexts in which these settings are embedded. The studies in this volume reflect an ecological perspective in the design of programs and policies (the decision, for example, that services must be delivered "within pram-pushing distance" of the individual client) that affect young children and families as well as in the design of research. In his foreword, Bronfenbrenner notes three critical features of successful intervention programs: 1) the empowerment of those who are the intended beneficiaries of policy and practice, since they turn out to be the principal agents of change; 2) the importance of discovering and responding to the *differing* characteristics, needs and initiatives of program recipients, with the program itself behaving as a social organism accommodating the families it serves; and 3) a recognition of the impact of perceptions, beliefs and meanings as well as of objectively identified conditions, events and processes.

New Interventions for Children and Youth: Action Research Approaches (1987)—Robert N. Rapoport (Cambridge University Press, 32 East 57th Street, New York, New York 10022) $39.50.

The author of this volume describes and analyzes ten projects in which behavioral science researchers collaborated with innovative service agencies in the children's mental health field in a collaborative-interactive relationship called "action-research." Because the projects involved "social inventions" rather than biomedical approaches using technical elements such as drugs or equipment, research efforts had to take account of natural settings rather than manipulate variables in a laboratory. The social inventions described involve "grassroots, piecemeal" changes rather than "large-scale utopian" designs; they include the Lower East Side Family Union's social service brokerage for at-risk families and the use of community-based support persons for teenage mothers to buffer stresses on the young mother and child.

Parent Education as Early Childhood Intervention: Emerging Directions in Theory, Research and Practice, Volume Three in **Advances in Applied Developmental Psychology** (1988)—Douglas R. Powell, editor (Ablex Publishing Corporation, 355 Chestnut Street, Norwood, New Jersey 07648) $35.00.

Since the late 1960's, notes Douglas Powell, parent education—an enterprise with white, middle-class roots—has been used as a form or a major component of early intervention aimed at parents of young children deemed to be developmentally at risk. The resulting program experiences, combined with profound social and demographic changes in American society, have shifted the field of parent education itself. This volume describes and reflects upon the experience of six parent-child intervention programs: the Syracuse Family Development Research Program; Cornell University's Family Matters Program; the Ford Foundation's Child Survival/Fair Start Initiative; Western Carolina Center's Family, Infant and Preschool Program; Illinois' Ounce of Prevention Fund Programs; and South Carolina's Resource Mother Program.

The Preschool Years: Family Strategies That Work—From Experts and Parents (1988)—Ellen Galinsky and Judy David (Times Books, 201 East 50th Street, New York, New York 10022) $19.95.

In her introduction to this amalgam of research knowledge and practical wisdom, Ellen Galinsky characterizes this book as a written form of the kind of parent support advocated by Bernice Weissbourd, Edward Zigler and other leaders of the family resource movement. Although the book is problem focused (because parents may first turn to books or seminars when they are experiencing a problem in childrearing), its emphasis is on family strengths, including the successful strategies devised by over 300 parents to deal with the predictable "rough spots of parenthood" in the years from two to five. Issues addressed include discipline, aspects of development, routines at home and away from home, special occasions, family relationships, family work, work and family life, and schools and child care. Broad themes that recur throughout the book include a recognition of the importance of individual differences in young children, an ecological perspective on child and family development, the power of expectations, a view of learning as a problem-solving process, the resilience of children, and interdependence as essential to parenting.

Beyond Individual Risk Assessment: Community Wide Approaches to Promoting the Health and Development of Families and Children (1988)—Robert W. Chamberlin, editor (Available free of charge from the National Center for Education in Maternal and Child Health, 38th and R Streets, N.W., Washington, D.C. 20057).

Risk factors that have been identified as contributing to parental dysfunction are now widespread throughout our communities, but resources are currently directed toward "rescuing" children after some disaster has occurred rather than toward reducing risk for the population as a whole.

This volume represents the proceedings of a conference held in November, 1987, sponsored by the Department of Maternal and Child Health, Dartmouth/Hitchcock Medical Center and the New Hampshire Department of Health and Human Services and funded by the Ford Foundation and the Division of Maternal and Child Health, HRSA, U.S. Department of Health and Human Services. The purpose of the conference was to learn from states and programs that have implemented community wide approaches to primary prevention some preliminary answers to the following questions: 1) When does it make sense to implement a community wide approach to promote the health and development of all families and children rather than concentrating resources on some particular high risk group? 2) What are the basic design elements essential for such a community wide approach? 3) What has been learned from state, local and public/private efforts, especially with regard to use of the mass media for "social marketing"? 4) How should such approaches be evaluated? Contributors to the volume include Robert Chamberlin, Christine Jackson, Katherine Kamiya Rubino, Richard Manoff, Emile Papiernik, Edward Zigler, Donald Pierson, and delegations from the states of Maine, Vermont and New Hampshire.

Early Prediction and Prevention of Child Abuse (1988)—Kevin Browne, Cliff Davies and Peter Shatton, editors (John Wiley & Sons, Inc., One Wiley Drive, Somerset, New Jersey 08875-1272) $39.95.

The contributors to this volume, an outgrowth of a conference organized by the Society for Reproductive and Infant Psychology, explore the causes and consequences of all forms of maltreatment—physical, psychological and sexual, active and passive—and their relation to the reliable and valid prediction, intervention and treatment of child abuse and neglect. Disciplinary perspectives represented include psychology, public health, education, law, midwifery, pediatrics, psychiatry, sociology, social work and social policy. In a chapter entitled "Breaking the Cycle of Abuse: Implications for Prediction and Intervention," Byron Egéland of the University of Minnesota presents evidence that while parental maltreatment of children is likely to occur across generations, a large proportion of mothers who were abused as children broke the cycle of abuse. These mothers were as children more likely to have had an emotionally supportive relationship with another adult and were as adults more likely to have an emotionally supportive husband or boyfriend. Egeland notes the importance of considering a combination of risk factors for purposes of early identification and prediction of maltreatment. He is encouraged by findings that psychotherapy for parents who were abused as children seems to be related to breaking the cycle and stresses that "the most important first step is to let parents who were abused as children know that they will not inevitably abuse their child."

NANCY P. ALEXANDER

The New Child Protection Team Handbook (1988) Donald C. Bross, Richard D. Krugman, Marilyn R. Lenherr, Donna Andrea Rosenberg and Barton D. Schmitt, editors (Garland Publishing, Inc., 136 Madison Avenue, New York, NY 10016) $52.00.

Multidisciplinary child protection teams have grown in 30 years from a few dozen to approximately 1,000, located in hospitals, departments of social services, mental health centers, on military installations, and in federal trial jurisdictions. The editors of this volume see such teams as working for children by working for professionals: professionals are continuously cross-trained by colleagues and emotionally sustained as well. The 36 chapters in this volume address a wide range of issues of concern to child protection teams: organizing case management teams; diagnostic tasks of team members and consultants; case conferences; the legal system and child protection teams; child protection team development, including training models; and trends, expansion and funding child protection teams.

Conference Call

March, 1988

March 15-18: The *National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)* will hold its 10th annual Nursing Conference on Pediatric Primary Care in Orlando, Florida. Dana Hughes will be keynote speaker. Workshops will address pain in children, the feeding relationship, health issues in day care and other issues. For information contact Anthony J. Jannetti, Inc., N. Woodbury Road, Box 56, Pitman, NJ 080701, tel: (609) 589-2319.

March 19-20: The *Pediatric Research and Training Center at the University of Connecticut Health Center* will hold its 4th annual Early Intervention Conference in Cromwell, Connecticut. Speakers will include Don Bailey, Pip Campbell, Marilee Comfort, Carl Dunst, Phillip Strain, and G. Gordon Williamson. Contact Cheryl LeTellier, Pediatric Research and Training Center, Division of Child and Family Studies, Department of Pediatrics, University of Connecticut Health Center, The Exchange—Suite 164, Farmington, CT 06032, tel: (203) 674-1485.

March 31-April 4: The *American Orthopsychiatric Association (ORTHO)* will hold its 66th Annual Meeting in New York City on the theme "Changing Families, Changing Responses: Reorienting Services and Programs." Edward Zigler will receive the 12th Annual Blanche F. Ittleson Lecture Award. A joint ORTHO-NCCIP one-day institute on Friday, March 31, will include G. Gordon Williamson, Jeree Pawl, Rebecca Shahmoon Shanck, Joanna Erikson, Sally Provence and Emily Schrag. For information, contact ORTHO, 19 West 44th Street, Suite 1616, New York, NY 10036, tel: (212) 354-5770.

March 31: *Franciscan Children's Hospital and Rehabilitation Center* (formerly Kennedy Memorial Hospital for Children) and *Boston University School of Medicine* will present their 5th Annual Pediatric Rehabilitation Conference in Newton, Massachusetts on the topic "Perspectives on Caring for the Child with Disabilities." Faculty will include Murray Feingold, John Anderson, Amy Bamforth, Francine Jacobs, Ruth-Ann Rasbold, and Deborah Klein Walker, among others. For information, write or call Mary Lou Fries, Inservice Education; Franciscan Children's Hospital and Rehabilitation Center, 30 Warren Street, Boston, MA 02135-3680, tel: (617) 254-3800, x151.

April, 1989

April 5-8: The *Canadian Child Day Care Federation* will sponsor a National Child Day Care Conference in Winnipeg, Manitoba with workshops, discussions, and visits/tours. Contact Canadian Child Day Care Federation, 120 Holland, Suite 500, Ottawa, Ontario K1Y 0X6, Canada, tel: (613) 729-5289.

April 7-8: *Lutheran General Hospital* will present a conference on "Continuing Care of the High-Risk Infant," to be held in Park Ridge, Illinois. Faculty will include Arnold Capute, Maureen Connors, Suzanne Evans Morris, Avroy Fanaroff, Marjorie Getz, Henry Mangurten, Seymour Metrick, David Sheftel, Kathleen Skuran, Ann Turnbull and Rud Turnbull. Contact Kim Walkup, Newborn Intensive Care Unit, Lutheran General Hospital, 1775 Dempster Street, Park Ridge, IL 60068, tel: (312) 696-5313.

April 8-16: The *Department of Social Work Services, Long Island Jewish Medical Center* and *Schneider Children's Hospital, Long Island Jewish Medical Center* will sponsor an interdisciplinary health conference in Lausanne, Switzerland entitled "Children at Risk." Faculty from Switzerland and the United States will explore social, psychiatric and pediatric dimensions of children at risk as well as professional, educational and research issues. For information, contact Ann Boehme, Associate Director for Continuing Education, Long Island Jewish Medical Center, New Hyde Park, NY 11042, tel: (718) 470-8650.

April 13-16: The *Southern Association on Children Under Six* (SACUS) will hold its fortieth annual conference in Richmond, Virginia. General session speakers will include Keith Osborn, Ellen Galinsky, Thomas Schultz, King Davis and James Comer. Pre-conference sessions will address quality in programs for children two and under and the integration of handicapped and typically developing children. Write to SACUS, Box 5403, Brady Station, Little Rock, AR 72215.

April 15: The *Maine Association for Infant Mental Health* will sponsor a statewide conference in Augusta, entitled "Children and Families: Building on Their Strengths." Emmy Werner will give the keynote presentation. For information, contact Anne Williams, 11 Maple Street, Rockland, ME 04841, tel: (207) 594-8474.

April 17-18: The *Michigan Association of Infant Mental Health* will hold its 13th Annual Meeting in Ann Arbor, Michigan, with the theme "Expanding Our Approaches with Families: Attachment, Intervention and Social Policy." For information contact Ann Saffer, 2340 Hichman Road, Ann Arbor, Michigan 48105, tel: (313) 994-8168.

April 19: The *University Affiliated Cincinnati Center for Developmental Disorders* will sponsor a regional conference in Cincinnati on "New Perspectives on Partnering with Families: Implications for Training Early Intervention Personnel." Marie Bristol and Gerald Mahoney will be keynote speakers. For information, call Marilyn Espe-Sherwindt or Chris Beatty at (513) 559-4321.

April 27-28: The *Family Child Learning Center* of Children's Hospital Medical Center of Akron will hold a conference in Akron, Ohio entitled "Early Intervention: The Roles of Families and Professionals." Speakers will include Carl Dunst, Kathleen Bishop, Georgia DiGangi, Rebecca Fewell, Winnie Dunn, Susan Harris, and Mary Beth Bruder. For information, contact Jean Markewski, Family Child Learning Center, 90 West Overdale Drive, Tallmadge, OH 44278, tel: (216) 633-2055.

April 27-30: *Save the Children* will hold its 12th Annual Family Day Care Technical Assistance Conference in Atlanta, Georgia. The Child Care Food Program Sponsors' Forum will be held in conjunction with the conference. Contact Joe Perreault, Save the Children, 1340 Spring Street, N.W., Suite 200, Atlanta, GA 30309, tel: (404) 885-1578.

April 27-29, May 3-5, June 1-3: *Contemporary Forums* will hold national conferences on neonatal nursing in Philadelphia, Pennsylvania; Denver, Colorado; and Anaheim, California. Contact Contemporary Forms, 530 LaGonda Way, Suite E, Danville, CA 94526, tel: (415) 820-2800.

May, 1989

May 4-5: The *Technical Assistance Program/Intervention Network* (TAP-IN) of Western Carolina Center will sponsor a conference in Morganton, North Carolina on "Parent-Professional Collaboration: Promoting Effective Communication." For information, call Karen Torrence at (704) 433-2670.

May 11-13: The *California Infant Development Association*, the *California State Department of Alcohol and Drug Programs*, the *California State Department of Developmental Services*, the *California State Department of Education*, the *California State Department of Health Services*, the *California State Department of Mental Health*, the *California State Department of Social Services*, and the *National Center for Clinical Infant Programs* (Project Zero to Three, Grant #113-771, Bureau of Maternal and Child Health and Resources Development, DHHS) will hold their Infant Conference '89 in Los Angeles, California. Entitled "Moving from Research to Practice: Directions for Implementing Infant Services in the Nineties," the conference will feature Jeree Pawl, Gail Christopher, Ann Rosewater and C. Arden Miller as plenary speakers. Major themes will include health and technology issues, family issues, service delivery, and policy and implementation issues. Write or call Infant Conference '89, c/o UAP-Children's Hospital, P.O. Box 54700, Los Angeles, CA 90054, tel: (213) 226-3454.

May 22-26: The *C. Henry Kempe National Center for Prevention and Treatment of Child Abuse and Neglect* and the *Department of Pediatrics, University of Colorado Health Sciences Center* will present the eighteenth annual Child Abuse and Neglect Symposium in Keystone, Colorado. Plenary addresses, seminars and case presentations will address healthy and unhealthy attachments, clinical and system intervention approaches, and legal management of child abuse, among other issues. Faculty will include members of the Kempe Center faculty and guest presenters. For further information contact Marilyn Lenherr, Training Administrator, Kempe Center, 1205 Oneida Street, Denver, Colorado 80220, tel: (303) 321-3963.

May 28-31: The *Association for the Care of Children's Health* will hold its 24th annual conference in Anaheim, California. The theme of the meeting, which will highlight model programming for hospital and community-based care, advocacy strategies, current research and clinical skills, is "Family Centered Care: Making It a Reality." Write or call ACCH Annual Conference, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016, tel: (202) 244-1801.

June, 1989

June 21-24: *Bank Street College* in New York City will hold its second annual Infancy Institute, entitled "Infants, Toddlers, Parents: Supporting Their Growth." Alice S. Honig will give the keynote address; the Institute will also include visits to infant/toddler programs, video presentations, and workshops. For information contact Nancy Balaban, Director, Infant & Parent Development Program, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 663-7200.

July, 1989

July 31-August 4: An *International Conference on Early Education and Development (0-6 years)* entitled "Childhood in the 21st Century" will be held in Hong Kong, with the support of UNICEF and High/Scope Foundation among other organizations. Conference topics will include the special needs of infants, training of early childhood personnel, family support, and policy issues, among others. For information, contact Tania Woo, International Conference Consultants, Ltd. 57 Wyndham Street, 1st Floor, Central, Hong Kong.

September, 1989

September 20-24: The *World Association for Infant Psychiatry and Allied Disciplines (WAIPAD)* will hold the Fourth World Congress on Infant Psychiatry and Allied Disciplines in Lugano, Switzerland on the theme "New Directions in Infancy." For information write to Hiram E. Fitzgerald, Department of Psychology, Psychology Research Building, Michigan State University, East Lansing, MI 48824-1117.

The National Center for Clinical Infant Programs' Sixth Biennial National Training Institute will be held December 1-3, 1989 in Washington, D.C. Its theme is "Promises to Keep: Directing research, resources and skilled personnel toward infants, toddlers and their families." A call for proposals will appear in the April, 1989 *Zero to Three*. Plan to respond, and to join us in December!

Zero to Three

Bulletin of
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Call for Posters, Symposia, Case Presentations and Videos for NCCIP's Sixth National Training Institute, December 1-3, 1989 See PAGES 26-27

The Professional Use of Self in Prevention

by
Judith Bertacchi and Julie Coplon
The Virginia Frank
Child Development Center
of the Jewish Family and
Community Service
Chicago, Illinois

"There are as many pathways to health and adaptation as there are to illness and maladaptive outcomes."[1]

Prevention/intervention: An unnecessary dichotomy

In the fifteen years that we have had established prevention programs for families with young children, our ideas about whom we serve, how we provide that service and how that service helps have changed. This article is about the therapeutic gains families make in prevention programs and the role of the professional in developing meaningful relationships within the context of a prevention program.

Prevention programs were often designed with dual purposes. Families experiencing normal stress associated with a life stage were expected to use prevention programs for education, support and/or socialization opportunities. The hope was that these programs would mitigate against the likelihood of symptom formation and prevent the need for clinical services. The helpful aspects of the programs were thought to be increased cognitive awareness and reduced isolation. For families who were already exhibiting significant symptom formation, prevention programs were viewed as a vehicle for referral to more intensive clinical services.

This view of prevention programs as distinct from clinical services did not adequately reflect the subjective experience of families.

DAVID GLADSTONE

Some families consider as normal and age appropriate child behavior and development that professionals would worry about. Some parents, for example, feel children must be trained by age one, and other parents are comfortable with their four-year-old's use of

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[1] Robert Emde, Infant Mental Health Journal, Vol. 9, #1, Spring, 1988.

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diapers. Early childhood professionals are likely to be uncomfortable with both of these extremes. But if a pediatrician or day care provider refers a family that is comfortable with their child's development to a clinical service, the family often feels confused, misunderstood or harshly judged. The family is more likely to end its relationship with the referral source than to act on the referral.

In prevention/family support programs designed for parents with infants or toddlers, the common experiences are more compelling than the differences between who has "symptoms" and who doesn't. The mother of a two-year-old who is anxious about effective strategies for toilet training may make a comfortable and helpful connection with the mother of the one-year-old and the mother of the four year-old also dealing with toilet training. At a drop-in morning or informal discussion group, families raise the issues that are uniquely triggered for them by the external stimulus of their child's development. (Professionals may understand the issues that are evoked and re-experienced in terms of attachment, dependency and autonomy or in terms of separation-individuation.)

The Virginia Frank Child Development Center is a district office of The Jewish Family and Community Service of Chicago. The Center offers a network of services to families and their young children. Included in the services are professionally led prevention groups,* counseling, a therapeutic Nursery-Kindergarten program and consultation to the community. Programs are run by an interdisciplinary staff of social workers, child development specialists and psychologists.

***Funding for the Prevention Program is provided by The Board of the Jewish Family and Counseling Service of Metropolitan Chicago and the following foundations: The Blowitz-Ridgeway Foundation; the Brand Companies Charitable Foundation; The Eisendrath Foundation; The Gelber Foundation; The Harris Foundation.**

Even for families without "symptoms" who are experiencing the normal stress associated with the transition to parenthood and the caretaking of an infant or toddler, the subjective experience of a prevention group is likely to be quite different from the description in the program design. Many groups for new parents, for example, are billed as "parent education." Yet a major psychological impact of the first stage of parenthood involves the reawakening of unconscious, preverbal issues stemming from a parent's own experience of infancy and toddlerhood. Precisely because this early experience is preverbal and not readily available to consciousness, "education" about such emotionally charged issues as dependency, helplessness, separation and autonomy is likely to fall on deaf ears. But the *relationship* to the professional leading the group, however limited, often serves as a powerful vehicle for the expression of these preverbal issues. In a professionally-led prevention program, preverbal issues are communicated through the nature of the relationship formed with the professional staff. Talk serves as the vehicle for forming these relationships, but content is seldom meaningful in and of itself. The issues that unfold and are enacted in the relationship with

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staff usually parallel the issues experienced between parent and child. How the staff members understand and respond to these issues becomes the core of the work that takes place, making the dichotomy between prevention and clinical intervention unnecessary.

For some clients, prevention programs are in fact the "clinical" service of choice. Significant work can take place in these programs even though, or perhaps because, the work is not taking place within a diagnostic framework. The client is not required to identify him or herself as needing help; she or he is not required to listen to a formulation as to what is wrong; and she or he is not required to enter into an agreement to work toward change. Many clients, and particularly many families at risk, are not able to see their way through one or all of those requirements, which are typically prerequisites for entering any treatment relationship.

Case vignette: Jane and Erika

Jane was an isolated mother whose beautiful two-year-old, Erika, could do no right. At the twice-weekly, drop-in mornings, Jane sat by herself, though she would respond if approached by a staff member. Her answers to our inquiries were always the same—complaints about how difficult Erika was. Erika had particular likes and dislikes, wanted to do things her own way, didn't want to cooperate with Jane, etc. When we responded that Erika was working on just the issues two-year-olds work on, Jane ignored us. But despite her negativism, Jane was open to being approached by staff and seemed to enjoy complaining to us. Slowly a parallel process began to emerge. The staff accepted Jane's negativism with interest and respect, and didn't try to change her attitude toward Erika. Over time, Jane's complaints about Erika didn't change, but the feeling she conveyed by her complaints did. Jane could speak of her own exasperation without focusing on Erika as a bad child. She began to describe Erika's difficult behavior with some humor and, we suspected, even with some pride.

> *"When a family that is comfortable with their child's development is referred to a clinical service, the family often feels confused, misunderstood or harshly judged by the referral source and is more likely to end its relation with the referral source than to act on the referral.*

As we accepted Jane's negativism and Jane began to accept Erika's negativism, Jane started to become more open to positive feedback about Erika. She also became more responsive to staff's attempts to engage her in conversation with other mothers. A year later, it was not unusual for Jane to arrive at the drop-in with stories of how adorable Erika had been. (It is important to note that a year later Erika was three and not two.)

Assessment and planning: Jane and Erika

When Jane and Erika first came to the drop-in they were isolated from other families. Jane's constant complaining about Erika didn't fit with the cute, developmentally-on-target two-year-old that staff saw. The first professional response of the team members was to generalize about the age-appropriateness of Erika's behavior in hope that the information would change the meaning of the behavior to Jane. Jane reacted to their "educative approach" by alternately ignoring the content of what they said and actively rejecting it. However, at no time did staff feel that Jane did not want to be approached. She simply responded to everything they said with a "no!". Staff's felt impulse was to be critical of Jane. Professionalism tempered this impulse, but was often ineffective in curbing the tendency to ignore Jane. In a room with thirty-five mothers and children, the tendency to ignore a particular mother-child dyad can be easily overlooked as a meaningful action.

The first part of assessment and planning is based on staff's observations of a mother-child dyad. Staff noted that Erika was a bright, curious, well-developed child. She had good verbal skills for her age and was able to explore the environment. Her attention span was age-appropriate. While she didn't particularly interact with other children, she was able to participate

Editors' Note

We're not sure who invented the phrase "the professional use of self," but we can certify that these words have been part of the mental health vocabulary for at least 25 years. While the phrase may sound not a little pretentious, it does convey an important home truth; people in the so called helping professions are themselves their most powerful tool. How they use this tool in their working relationships has a great deal to do with the success or failure of these alliances.

We got stuck in the previous sentence as we began to write "their relationships with..." and wondered what word to put next—"clients"? "patients"? "program participants"? These are all terms that can appropriately be used to describe the professional's partner in a therapeutic alliance. Each term, however, connotes a somewhat different relationship, with unique assumptions and rules about the boundaries of the relationship, its formality, and the allocation of authority within it.

The articles in this issue of *Zero to Three* vividly describe and thoughtfully analyze how professionals from a variety of disciplinary backgrounds "use themselves" in programs or settings designed to support families in the tasks of rearing their infants and toddlers. The philosophical assumptions underlying their work derive from the specific disciplines of clinical psychology, social work and the developmental therapies; they also reflect a general, continuing reexamination of the professional use of self. We hope that professionals, parents, administrators and program planners will find the insights of these authors helpful.

in the one organized activity (Roll the Ball). She was physically well-cared-for, well-groomed and dressed, and she was a very pretty child. Staff didn't see much of the negativism that Jane described, but they began to see in Erika a depressed affect that mirrored Jane's. Mother and child avoided each other during the course of the morning, each of them seeming alone and isolated. While Jane's negativism colored all of her interaction with Erika, she was very concerned about her daughter and could describe her with great accuracy. Jane continued to care for Erika and didn't try to avoid her by putting her in a program by herself. Instead, Jane chose to bring Erika to a mother/child drop-in, run by a child development center and led by professional staff.

The second part of assessment and planning is based on the nature of the relationships mother and child form with professional staff and the feelings evoked in staff by the relationships. Staff was unanimously critical of Jane. This was noteworthy, as clients sometimes share different parts of themselves with different staff members and the feelings staff have about a parent can be quite diverse. Staff members also have different personal reactions to and toleration of various parenting difficulties and this too accounts for staff having different reactions to clients. But with Jane, each staff member felt annoyed, critical and ineffectual. Jane rejected all of their kind, helpful, educative and supportive input.

The third part of assessment and planning is based on how theoretical understandings are applied to a particular mother-child dyad. Based on how well developed Erika was, staff speculated that the relationship between Jane and Erika had been basically positive until Erika's budding autonomy had been expressed through negativism. Staff speculated that Erika's negativism had rekindled in Jane her own early issues that had not been worked through. As these issues were basically preverbal, Jane was not able to tell staff about her experiences as a two-year-old, but was re-enacting them with staff. Staff decided that their task was to accept Jane's negativism and in this way help her accept Erika's negativism. While the supportive and comfortable atmosphere of the drop-in may have been enough to help Jane weather Erika's "terrible twos", it was the therapeutic relationship with staff that allowed Jane to grow from the experience of this phase, not just to survive it.

Case vignette: Sallie and her three little girls

Sallie and her three little girls were brought to the drop-in by a friend. Sallie's double buggy only accommodated two of her three children,but her friend had a double buggy with a vacant seat. When the team tried to comment casually on her children's play she responded in sentences that trailed off and left staff hanging. Though there were concerns about Sallie and her children, staff members backed off. Sallie was always greeted warmly. Attempts were made to make her comfortable with the group and to facilitate her children's participation.

Betsy, aged two and a half, seemed depressed and withdrawn. At times she played and at times she fought with her younger sister Ann, aged eighteen months. Ann was an outgoing, spunky child who had the greatest ability to engage Sallie. Rita, the baby, was just a few months old and was left in the buggy for most of the morning or was nursed. Sallie, who looked to be about twenty-five years old, seemed passive and depressed. She usually sat with other mothers. At times Sallie was aware of her children and available to them; at other times she did not seem to hear or see them. Her children were relatively well-behaved, but had a forlorn quality about them.

After a number of weeks, Sallie came to drop-in and came right up to Helen, the team leader. Her friend told her to do this. She launched into a long, wordy narrative about Betsy. She felt Betsy was too rough with her younger sisters and nothing Sallie did helped the situation. As Sallie talked, Betsy approached and began to pat the baby, who was on Sallie's lap, and continued to pat her more and more roughly. Sallie seemed not to notice.The rough pats continued and finally Sallie said, "See what I mean?" Eventually, in a tired and defeated voice, Sallie told Betsy not to hit her sister. After Helen had discussed various ways Sallie could handle the situation, Sallie said that her friend had assured her, "Rebecca can help you with this!" Helen then gently explained that she was Helen, not Rebecca, but she was still very glad that they had spoken.

Sallie continued to talk to Helen over the next several weeks. Her basic complaints of helplessness and hopelessness remained unchanged, but two themes began to emerge. Betsy, aged two and a half, was a bad and immature girl because she fought with her sisters, and Sallie would be criticized by her family because her children weren't well-behaved. A pattern began to develop between Helen and Sallie. Sallie eagerly sought Helen's advice about this issue, but none of her advice helped. Helen felt ineffectual, helpless and hopeless. Sallie continued avidly to seek advice on this same issue. This is as far as the relationship has progressed.

Assessment as a dynamic process: Sallie and her three little girls

At this point, the staff member does not know enough about Sallie to explain or understand the nature of the relationship developing between them. What the staff member does know at this point is that: 1) she will not insist on focusing on a technique for handling the sibling rivalry; 2) she will not suggest that Sallie talk to other staff members who might have better ideas about handling sibling rivalry; and 3) she will not discourage Sallie from reiterating the same complaints again and again.

Instead, the staff member will listen to Sallie and try to be aware of her own impulse to turn a deaf ear to her, i.e., passively to let Sallie complain while disengaging from any meaningful attention to her. The staff member will watch Sallie do this to her children, who are basically well-behaved, well-endowed children. The staff member will think about Sallie's expectations that Betsy be grown up at age two-and-a-half because the baby carriage only has two seats. And she will think about Sallie's inability to be helped by her; after all, her suggestions were good ones. The staff member will sit with Sallie and listen to her. She will talk to her

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about Betsy's strengths and how young she really is. Mostly she will talk to her about how hard it is to be the mother of three children under the age of three.

The staff member will not expect Sallie to respond to her observations or even listen to them. But if Sallie and the staff member sit together and the staff member listens to Sallie and, most important, does not expect anything of Sallie (for example, that she should be more grown up and competent than she is and that she should do what the staff member tells her to do) then this relationship has the potential to help Sallie. It also has the potential to improve Sallie's parenting even though she will never follow any of the suggestions that she will continually require the staff member to make. The task for the staff member in prevention, like the task for a therapist in a conventional treatment setting, is to use an on-going assessment of the nature of the transference as a basis for further assessment and planning.

Supervision

The same principles that guide our clinical parent-child work are fully operative in prevention programs. Staff members working in prevention programs need supervision that includes support and attention paid to the parallel process issues being enacted within them. Just as parents re-experience the issues and affects of their children, so do caretakers and professionals working intimately with these very same issues. The issues may be readily observed and felt in the young children but only experienced in an affective mode through interactions with the parents. In order to be successful, staff must maintain an openness to examining their reactions aand their feelings, both positive and negative, toward the families who come.

Staff members also grow in their ability to assess functioning and form hypotheses in the here and now; that is, within the situational moment and in any environment where the family is met by the staff. This could be in a corridor, a bathroom, a busy group, the lobby or a hospital room. Frequently, professional staff members working in prevention function as a team. Supervision must enable them to share with each other, to raise differences of opinion, differences of perception and to tolerate conflict and tension. With time, they gain in their ability to understand these tensions as not solely personal issues but further refinements of communications from parents and their young children.

There are specific tasks and strains for staff working in prevention. An overriding task for staff is to become comfortable with utilizing their clinical acumen, but implementing it in very different ways from a clinical interview. For example, the skill of assessment is used for, planning interventions that are within the scope of the boundaries of the program (See Jane/Sallie.) The contract existing between a staff member and a family is a subtle one and time-limited, i.e. "I am coming to your professionally-led preventive service for today, based on what I read in a flyer or heard from my friend or neighbor." Supervision addresses this task by exploring the contract that is operating between staff and families within any preventive experience. The limits and boundaries of intervention need to be frequently clarified.

Staff does not always receive feedback on how a family is doing or how a particular discussion or comment was understood by the parent. This leads to concern and worry about certain families, especially those considered vulnerable or at risk, and who have not, for example, "dropped in" lately. The supervisory task is to listen and participate in the concerns, thus sharing and at times containing the anxiety. Frequently, the supervisor's task is to review the fact, easily lost, that the family knows we are here; again, holding to the contract.

Staff members working in prevention programs need supervision that includes support and attention paid to the parallel process issues being enacted within them. Just as parents re-experience the issues and affects of their children, so do caretakers and professionals working intimately with these very same issues.

Staff members struggle continually to make themselves desirable attachment figures. Within this process they accept the complex communications resulting from these attachments. The non-verbal dynamics of the group process and the expressed, ongoing normal maternal dependency needs of mothers in this life stage can continue to create in staff a phenomenon of wanting to do more and more for parents. Momentarily they can feel just like the mother, being prone to similar regressions and defensive stategies. The supervisor's task is to work toward helping staff accept those very same maternal feelings of neediness and occasional entitlement. That shared experience, if understood, can deepen the empathy team members gain for the parental tasks of this life stage.

This task often comes forward when families begin to request changes in the limits and boundaries set within a program structure. By virtue of being "outside the process" the supervisor becomes aware of staff regressions paralleling the parents and of guilt beginning to drive decision-making. To understand and empathize with a parent's neediness and sense of entitlement is quite different from being caught up in this neediness. To hold limits in an empathic, respectful manner is to accept the parent but interfere with their potential to destroy the very "holding environment" for them as parents that they crave. The supervisor works to help staff regain perspective; then staff can provide without burning out or beginning to hate those who ask so much of them. Again, the supervisor points out the close parallel to a primary parental task.

Staff members in prevention programs learn to advise more freely than is usual in some of their clinical work. They gain in their ability to understand that their advice will not always be taken and may be serving another purpose within the transferences that develop between parents and staff. They learn to participate in small talk while using their clinical skills in understanding metaphor and transference.

The team and staff are uniquely strained by those families who, in their vulnerability as parents, present staff with multiple examples of "bad parenting".The supervisor must continually hold out "hope" to staff working with these high-risk families. This is particularly true at those times when team members begin to feel the despair and exhaustion shared with them by the families. This sharing may occur when quietly sitting with a mother who looks depleted, depressed and/or is not available to her child while she is with us. This intervention is a poignant non-verbal communication occurring within a preventive transference relationship. Further, the supervisor can also point out the value of this mother being less isolated, being "held" while observing other parents who are functioning. We have learned that a mother in distress does not necessarily spoil the experience for other mothers (an early apprehension of ours). Being with a parent who is struggling can provide relief for other parents. They observe and realize that they might not be the only one who ever faltered in their parental tasks.

In parallel fashion, the supervisor sits with staff and listens. By sharing observations of slight change in the family or reviewing the unresearched value of caring for the mother and providing respite, the supervision goes beyond listening and provides ongoing training. The supervisory support lies essentially in the theories that help us better understand both adult and child personality development within the context of a caring, informed relationship.

Supervision helps staff deepen their understanding of parental ambivalence as they explore their own complicated reactions to certain parents and children. Our teams are frequently made up of social workers and child development specialists. Thus the staff teams often represent the continuum of identifications from baby to mother. Their positions and belief-systems slowly undergo change with all ideally moving to a more middle-of-the-road, dyadic stance. Those who always move first to the children will need to recognize with Winnicott that, "There is no such thing as a baby"...only a mother/father and a baby. Those who enter the work from the other end of the continuum, focused on the mother, will learn to appreciate the expanding parental identity struggles that always include the child. The learning task will become to paraphrase, "There is no such thing as a mother, there is always a mother and child." The internal changes necessary for dyadic work do not diminish the unique insights and talents that individual team members need to share and utilize. It only means that interventions need to be dyadic and directed toward the parent-child relationship. The supervisor's task here focuses on the talents of the team members. This is a crucial task for the team, to learn to focus, discuss and plan interventions for dyads, rather than individual parents or children.

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Summary

The professional use of self in prevention is the process by which a staff member lends him/herself to enter the arena of preverbal issues. Staff make themselves available to receive these communications through the relationships they form, through the role they have been assigned by a client and the feelings that role evokes in them. Staff members use these experiences to form speculations and hypotheses a client might be struggling with. The process usually involves use of supervision to [illegible] and [illegible] the [illegible] preverbal issues that are [illegible] in any [illegible] this. Staff member and supervisor form [illegible] assessment of the family [illegible] and [illegible] assessment to guide staff action.

While [illegible] prevention programs [illegible] mean therapeutic [illegible] they are a special [illegible] with infants and toddlers [illegible] preverbal [illegible] are [illegible] parenting during the [illegible] programs are designed to [illegible] together, preverbal issues are [illegible] part of the relationship between parents and child and often reproduce themselves in the relationship between parent and staff member. It is careful attention to the parent-professional relationship within prevention programs that allows them to serve as vehicles for change, instead of vehicles for repetition.

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Recurring Questions for Family Support Practitioners

by
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With its emphasis on self-help, peer support and parent empowerment, the family support movement has had a subtle but profound effect on parent-professional relationships. The deficit model of service delivery, in which a professional comes to the "rescue" of an ailing family, has been replaced by the family support model, in which the professional acts as a resource to the family, contributing expertise and assistance in a way that respects the family's integrity and promotes competence and independence. Parents expect to be treated as equals, and they expect to stay in charge of the decisions that affect their families.

While family support programs are committed to respect for the parent's point of view, there are times when remaining neutral is not possible.

The Family Center of Nova University offers a variety of programs for parents and children that incorporate the philosophy of the parent support movement. A major programmatic thrust of the Family Center is the parent-child program. In classes for parents and young children, the Family Center staff provides an activity oriented curriculum followed by an open-ended group discussion. During group discussion, teachers provide parents with current information on child related issues without imposing their own opinions or personal values.

While the Family Center respects the parent's point of view, there are times when remaining neutral is not possible. If a parent is obviously inappropriate with a child and the child's well-being is at risk, the staff intervenes with no hesitation. In other situations the course is less clear. There is a fine line between appropriate redirection with families who are not acting in the best interest of their child and inappropriate redirection based on a difference in child rearing values, beliefs or perspectives. Families have a right to decide what is good for their child even if we disagree. Furthermore, staff must be careful not to allow their well meant suggestions to jeopardize the trust and confidence of parents.

The two vignettes that follow present situations in which Family Center staff were concerned about the impact of a parent's decision on the child's development. One family had enrolled their baby in an infant training program that we felt was inappropriate. Another family was slow in accepting their baby's need for evaluation and treatment for developmental problems. In each situation, staff considered making specific recommendations and discussed their concerns with colleagues and supervisors. With both families, the decision to remain supportive yet nondirective was validated by the outcome.

FLORENCE SHARP

Katherine, Nicky and the flash cards (as told by the classroom teacher)

Katherine attended the Family Center parent-child classes for the first time when her son, Nicky, was 18 months old. She was a self-assured and energetic mother and volunteered to open the parent discussion by talking about her son. "Nicky is enrolled in an academic early reading program," she told the group. "I bought flash cards designed to teach babies to read, and you would be amazed at how much he already knows. You know their little minds are just like sponges at this age and you've got to get in all the teaching you can." I was unsure about how to respond to Nicky's mother. Presenting flash cards to an 18-month-old child was counter to everything that the Family Center believed in. Fortunately, before I had a chance to respond, other mothers began to talk about their children and the conversation moved in another direction.

During the next staff meeting I talked with the other teachers about Nicky's flash card program. Should we explain to Katherine that the Family Center does not endorse this program's philosophy? Should I try to explain that teaching babies to recognize flash cards is developmentally inappropriate? Did we, as a Family Center, have the right to impose our own values on Katherine, and try to redirect her interactions with Nicky? Recognizing that Nicky was a perfectly happy little boy, we decided that it would be intrusive for me to intervene.

Nicky and his mother continued to attend parent-child classes. Nicky was an active and curious youngster who kept himself busy from the moment he entered the class. One day one of the mothers asked if Nicky

The Family Center of Nova University

The Family Center of Nova University, Ft. Lauderdale, Florida, is a family support program that provides a wide spectrum of services for families with children. Funded through foundation grants, government grants and client fees, the Family Center has a special committment to families with young children, lower SES and minority families, and families whose children are developmentally at-risk. The following special programs are sponsored by the Family Center:

Programs based at the Family Center:

Parent/Child Classes: The parent child programs provide an opportunity for parents and children to share experiences that promote healthy social-emotional, physical, and cognitive development. The classes are predicated on the belief that play is of primary importance for the development of the child and the parent-child relationship. Parents are tuned in to developmental expectations and emerging events and gain an increased awareness of their children's unique personalities and capabilities. Parents are encouraged to play with their babies, and staff are instructed to interact with parents in a supportive and non-obtrusive way.

Discussion time is a vital part of parent-child classes. During this period, issues related to child development and child management are introduced. Group discussions provide an opportunity for the development of parent-to-parent as well as parent-to-professional bonds. Parents are provided with current information on child related issues and are encouraged to draw their own conclusions and make their own decisions.

Pre-School Program: The Family Center programs extend to children 2-4 years old who attend preschool classes. The focus of the program is on the development of cooperation, creativity, cognitive development and communication skills. Parents play an active role and are encouraged to participate in classrooom activities.

J.L. Mailman Developmental Clinic: The Family Center provides a multi-disciplinary developmental clinic for the evaluation of infants and young children with developmental problems. Therapeutic services include child management, family counseling, developmental therapy and play therapy.

Ring-A-Round: The Ring-A-Round program is an early intervention and social interaction program for parents and children birth to 3 years who are "at-risk", delayed or handicapped. Families participate in a variety of music, movement, sensory, motor, problem solving, and language activities presented at appropriate developmental levels. These activities are open-ended and success oriented and provide the opportunity for positive parent-child interaction. Parent discussion time focuses on practical aspects of child care and topics that promote the sharing of information and feelings.

The Family Center is committed to providing innovative programs and services to lower SES and minority populations within the community. These programs include:

Child Abuse and Neglect: In association with Broward County Child Care Connection, the Family Center has designed and supervised therapeutic preschool programs for children under five years old who have been placed under protective custody. This therapeutic program is used in centers county-wide. The Family Center provides psychological consultation, child assessment, individual programming and program evaluation.

Building Blocks: Building Blocks is an infant-toddler center in Palm Beach County for low income migrant children and their parents. The Family Center was instrumental in the initiation of the Building Blocks program, and has been responsible for staff training and supervision.

Academic Programs:

The Family Center, in conjunction with the Nova University Center for the Advancement of Education, offers a Masters of Science program in Child Care Administration with a specialization in Family Support studies. This off campus program utilizes a directed study format and allows for specialized training without interruption of the graduate student's present position.

was still reading flash cards. "No, he got kind of tired of them," his mother explained, "Besides, it's sort of a dumb idea to teach a baby to read."

When Katherine's teacher told the staff about Katherine's disenchantment with the flash card program, everyone was delighted. We realized that the decision not to confront Katherine with anti-flash card arguments had been a wise one. If we had tried to impose our point of view before Katherine had a chance to experiment on her own, she would have been less likely to remain open minded. Nicky was a sturdy and determined youngster, with a mind of his own. He did a much better job debunking the flash card program than any of us could have done.

Ready to hear about Joshua (as told by the program director)

When Alicia came to the Family Center with her son Joshua, the staff was already familiar with Joshua's history. Alicia's younger sister was a regular participant at the Family Center and had often talked to the staff about her concern with Joshua's development. Joshua's aunt described him as small for gestational age baby who took a long time to regain his birth weight. At three months his head was still floppy, his tongue protruded and he held his left hand in a tightly fisted position. Of even more concern to his aunt was Joshua's mother's relationship with her baby. Alicia was a practicing lawyer, and Joshua spent most of his time in the care of a nanny. Even when she was not working, his mother spent little time with him. It was the aunt's hope that if she succeeded in getting her sister to attend a parent-child class, the staff could talk to her sister about Joshua's development and perhaps suggest a developmental evaluation.

When Joshua was four months old, Alicia enrolled in a parent-infant class. During her first visit to the Family Center, Alicia appeared to be ill at ease. She avoided talking to other parents and did not participate in the group discussion. Joshua slept through most of the class. When he finally awakened, he seemed overwhelmed by the activity in the room. He cried hard for a few minutes, drooped his head on his mother's shoulder, and fell back to sleep.

Alicia attended the Family Center classes regularly for the next three months. Although she still stayed away from the other parents, she began to play more actively with Joshua, and to participate in the group activities. Joshua too was showing definite signs of progress. His tolerance for noise was increasing. He was reaching out for toys, and smiling responsively when other mothers approached him.

Despite the obvious progress that Joshua was making, his teacher had serious concerns. Joshua's mother was spending a lot of time watching the other babies. At the teacher's request I came into the classroom and spent some time playing with Joshua. Alicia watched me for a few minutes, then asked if I was testing Joshua. I told her that I was the program coordinator and that I often came into classrooms. My office was across the way if she wanted to come in and talk. Alicia did come into my office after class, but she was reluctant to share her real concerns. "You know, some of the mothers have been bringing their babies in with runny noses. You really should ask them to keep their babies home." I agreed that that would be a good idea, and asked if she had problems with Joshua getting colds. She told me that he was pretty healthy and she wanted to keep him that way. As she walked out of the room rather abruptly I had the feeling that I was being tested.

A week later, following class, Alicia came back to my office. She began talking about how pleased she was with Joshua's progress. The only thing that concerned her was Joshua's tongue. He had a habit of sticking it out and it made it hard to feed him. Did I have any suggestions? I thought of asking Alicia if she had any other concerns, but changed my mind. Instead, I described some techniques that might help Joshua get used to a spoon.

During the next several months, Alicia continued to attend the parent-child classes on a regular basis. After each class she made a point of stopping off at my office. Sometimes she just wanted to talk about the class activities, but more and more frequently the conversation focused on her concerns about Joshua. "He's within the range of normal," she would say, trying to reassure herself. "Didn't I agree?" Without being overtly confrontive, I suggested to Alicia that she was feeling some concerns about Joshua's progress. We talked about different ways that children can be helped if their development is off course, and I introduced the idea of a developmental evaluation.

When Joshua was 14 months old, Alicia returned to my office and shut the door. Almost tearfully she told me about her decision to have Joshua evaluated through the Family Center's developmental clinic. She was really beginning to worry. The other children in the class were all walking and Joshua wasn't even pulling up. She asked that I not tell anyone about the evaluation, as she didn't want him labeled, but if there was something that could be done to help him catch up she would like to find out about it.

I was concerned when Alicia left the room. What would they tell her about Joshua? Would Alicia be crushed if she was told that Joshua was not developing normally? On so many different occasions I had been tempted to suggest a developmental evaluation, yet I

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always held back, recognizing that Alicia was not ready to hear. Was she ready now? I thought about Alicia. She was a lawyer, bright, educated, concerned. Certainly she knew all along from watching the other children that things were not right with Joshua. Her downplaying of Josh's problems may have been her way of buying time. Alicia was aware of her own strengths and vulnerabilities. Before she could rally the resources to begin a therapeutic program, she needed playtime with her son. She needed the opportunity to be like every other mother sharing fun activities and enjoying her son's responses. Over time, Alicia became more aware of Josh's unique characteristics and special charm. She also came to recognize her own capacity for unconditional love. Finally, she felt ready to focus her attention on Josh's problems and get him the help he needed. Just as I had been careful not to interfere when Alicia was pretending to herself, I had to be equally careful not to interfere with her decision to find out the facts.

Contrasts, commonalities and challenges

The two scenarios we have presented are quite different from each other. In the first case we had a healthy youngster and a misinformed mother. Once the Family Center recognized that Katherine's baby was not being compromised, the decision not to intervene was an easy one to make. The second case was more difficult, and we spent a long time debating about what our role should be.

Should we make clear to Alicia that Josh had a significant problem that required intervention, or should we give her the time and space to come to her own conclusions? We realized that our own disposition to act on problems as soon as they arise might lead us to create a false sense of urgency. Our ultimate decision to listen rather than recommend was a wise one. Alicia needed to stay in charge, not only of the decisions that affected her son but also of the timetable for making those decisions.

As we evaluate our experiences with parents like Katherine and Alicia, we recognize the challenges of putting into practice our beliefs about parent-professional relationships. Parents come to a family support program with different agendas, different degrees of insight, and different coping strategies. Our professional interaction with families must be responsive to these differences, yet genuinely respectful of each family's integrity. Our practice must reflect our deep-rooted belief in the family's ability to make decisions supportive of their child's best interests.

The Effectiveness of a Feeding Support Group as an Adjunct to Other Therapies in an Early Intervention Program

by

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Newton-Needham Early Intervention Program

A baby's capacity to eat and parents' ability to feed their baby are basic concerns in any family. When an infant's health and development are already compromised, feeding can assume paramount importance. Unfortunately, parental anxiety about feeding may be so intense, and the determination to "get food into" the child so urgent, that the parent may become insensitive to the baby's cues, disregard the baby's self-feeding skills, or otherwise sow the seeds of an ongoing power struggle around food.

At the Newton-Needham Early Intervention Program in Massachusetts, a feeding support group has been highly successful in promoting growth and positive change among young children with feeding difficulties and their caregivers. In an emotionally supportive group of peers, caregivers are able to share both concerns and skills. The group is a safe place to try new ways of feeding and can also ease the isolation that parents of sick babies often feel so acutely.

Referrals to the feeding support group come from our programs for premature infants, for infants at environmental risk, and for multiply handicapped infants. Reasons for referral range from mechanical, oral motor problems to interactional dysfunction between baby and caregiver. In some cases the mechanical difficulties or structural problems are the result of diagnosed medical conditions or genetic disorders; in other cases there is a combination of interactive and oral motor difficulties.

The assessment procedure for the group makes primary use of the N.C.A.S.T. Feeding Scale developed at the University of Washington, and an oral motor evaluation. We have found the N.C.A.S.T. evaluation particularly helpful in assessing the quality of interactions for it focuses on the caregiver's sensitivity to the child, the caregiver's response to the child's distress, the caregiver's fostering of social-emotional growth, the clarity of the child's cues, and the child's sensitivity to the caregiver.

The oral motor evaluation looks at the mechanics of oral processing: function of oral musculature inclusive of tongue, lips, cheeks, and jaw, as well as types of food and utensils currently used and the positioning of the baby during feeding. Sensory variations like tactile defensiveness (particularly around the mouth and in the hands) or poor discrimination skills are also evaluated.

Further intake considerations include reason for referral, medical background, developmental milestones (quality and quantity), interventions made prior to the group, and changes observed prior to the group.

We have learned that discussion immediately following the assessment, when caregivers can express their concerns and we share our observations and suggestions, can be a cathartic experience. The caregivers have allowed outsiders (often strangers) into their house to observe what often is the most traumatic time of their caregiving day. From their point of view we have seen them and their baby at their worst. They have shared many of their inner fears and frustrations about feeding and about their child. Despite our efforts to soften the experience, the assessment can be painful. The feeding support group takes on added value as a safe holding environment following the revelations of the assessment.

The Newton-Needham Early Intervention Program, under the auspices of the Newton-Needham Mental Health Association, provides services to children from birth to three years of age who are exhibiting, or are at risk for, developmental delays. Three distinct components of the program address three particular populations: the Premie Program services premature infants and their families; the Environmental Risk Program services children in families experiencing difficulties originating from mental illness, alcoholism, or socio-economic stress; and the Multiply-Handicapped Program serves children who are delayed because of a variety of diagnosed and undiagnosed conditions.

Referrals to the Multiply-Handicapped Program include children with known medical conditions, for example, neurologic, orthopedic, and genetic syndromes, as well as children with delays of unknown etiology. The areas of development that the program focuses on are speech and language, gross motor, fine motor, cognitive, and social/emotional.

The program is staffed by an interdisciplinary team of physical therapists, occupational therapists, speech and language pathologists, social workers, and a teacher. Home visits and center-based classes are offered for children. Parents' needs are also addressed through home visits, educational meetings and support groups.

A social worker and an occupational therapist co-lead the feeding support group, which meets for one hour sessions on a weekly basis for six to eight consecutive weeks. After each session we have a break of a few weeks. The group meets at our center in a room with a large table to sit around, with toys and floor mats for the children when they are finished eating. So that participants can "feed and be fed" we provide the basics for a salad bar for the adults while the caregivers provide their child's lunch as well as a food contribution to the

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salad bar. This arrangement allows parents of fussy eaters the chance to furnish food for an appreciative group as well as to receive food from others.

When participants first arrive for group we encourage them to position and start feeding their child as soon as he or she shows signs of hunger. Co-leaders use this time to circulate around and provide one-on-one attention. Hands-on help, such as showing the angle to hold the spoon for feeding, may be offered.

After the children are fed, they are welcome to play or sleep, and the adults move into a discussion time. This is a chance for caregivers to set goals, report on progress, share difficulties, and consider common feeding concerns. The leaders make an effort to help members hear each other and offer suggestions and support based on common experiences or new ideas. We occasionally invite consultants to speak about infant nutrition; correlations between feeding development and speech; proper positioning for feeding; or encouraging cognitive growth during feeding time. The group ends with a wrap-up summary statement by one of the leaders.

We have been extremely pleased with the positive results of this support group. Children are reevaluated every six months and at termination from the group, using both the N.C.A.S.T. evaluations as well as the oral motor evaluation. We have seen the N.C.A.S.T. subscores raised, often dramatically, as well as increased oral motor function documented. Moreover, early intervention staff from other parts of the program have observed that parent-child dyads who have participated in the feeding group are more receptive to other forms of treatment. This seems to suggest an increased openness on the parents' part and an increased capacity of the parent-child combination to work together to foster other areas of development.

The group works to facilitate change, and we considered several issues in designing our group. We promote the emotional safety of participants through the structured use of group time. The emphasis on education, information and skills rather than on feelings further enhances safety, and the "social" setting of eating together can be a relief for caregivers for whom feeding is usually a stressful time.

To encourage change, feeding is approached as an ongoing process with a definite developmental sequence (sucking, chewing, spoon feeding, finger feeding, use of utensils) with the goal of independent feeding. This approach allows the leaders to meet the participants where they are in that continuum. It also helps caregivers focus on the immediate skills and needs of the child, and promote the next developmentally appropriate stage. We have found that sensitivity to participants' timing is important. Some parent-child dyads may be able to work out their feeding difficulties within one series of group sessions; others may take an entire year to make steady but very slow progress.

Co-leadership, an important part of the group design, provides the flexibility for some one-on-one, hands-on attention during group time. The presence of two leaders provides modelling for participants that demonstrates the ways in which two people can work together by listening to, questioning, observing, and supporting each other. Co-leadership also offers a cross-disciplinary approach that provides training, experience, expertise, and knowledge from more than one perspective. Particularly in an area as complex and multifaceted as feeding, the combination of more than one discipline is essential.

David and his family

David and his family illustrate the effectiveness of the feeding support group in meeting some very particular needs. The support and information David's mother, Jan, received in the group helped her to see him as a competent and successful child. She was able to relax and to offer him space and time to eat and grow at his own pace.

Concurrent with this group, David's father, Philip, was able to establish a more accepting attitude toward David and enjoy his company more fully.

History

David was born overseas to parents in their early thirties. Hi sister, three years old at the time of his birth, was described by her mother as cute, bright, healthy and easy; this "perfect" daughter was very close to her father. David, however, was born seven weeks prematurely. Although he weighed a healthy 7 pounds at birth, his mother, Jan, described him as a sleepy, passive infant who was difficult to waken for breastfeeding.

When David was three months old, the family moved to the States. It was noted that David's head was unusually large and that he had poor head control. At four months, David's weight gain began to fall sharply. Jan expressed her concerns about the baby's slow weight gain, motoric passivity and fussiness around eating and sleeping to David's pediatrician. The physician expressed the belief that all the problems would be resolved if Jan would only feed David enough. Jan reported feeling unsupported, frightened and blamed.

During this stressful period, Philip showed little interest in David or support for Jan. He admitted that he does not like babies until they can walk and talk and had little to do even with David's sister until she was a toddler.

When David was thirteen months old, Jan decided to have him evaluated by a pediatric neurologist, against David's pediatrician's advice. The findings of this examination were megalencephaly, failure to thrive, and developmental delay. At a follow-up neurology exam three months later, excessive drooling was noted, a C.T. scan exhibited "disorganization of the central nervous system," and the family was referred to our program for early intervention services.

At seventeen months David entered our program. Jan reported feeling worried that David had so many problems, but also felt relieved that her concerns were confirmed and that there was help available to David and to her. At the time of our initial evaluations, David was reported to be delayed in all areas of development. A gross motor evaluation noted delay in all major milestones and fearfulness as David attempted gross motor tasks. A fine motor evaluation noted David's low muscle tone, and a one to two month delay, even when using his adjusted chronological age. It was also noted that mother tended to treat him as much younger than his age and his skill level.

The initial treatment plan for David and his family included enrollment for David in our twice-weekly Pretoddler Class, which is staffed by therapists in all developmental disciplines. He would also be involved in bi-weekly individual physical therapy. Jan was invited to attend a weekly support group; Philip was invited to be present at home visits and to attend a parent conference in a few months. David and Jan were also referred to our Feeding Team as possible participants in the feeding support group.

A social worker and an occupational therapist performed the NCAST Feeding Evaluation at home; an oral motor assessment was made during the same feeding. Jan offered David yoghurt, oatmeal and scrambled egg by spoon; the only finger food offered was a large piece of banana. During the feeding we observed Jan's tension, hurried pace, lack of sympathy when David was distressed, and lack of humor or encouragement. Although David clearly said "uh-unh" when he refused the spoon, Jan continued to offer it, to David's increasing distress. We noted that David's eyes were constantly on his mother and that the only thing he ate were bits of the banana, which he could control. The OT noticed that David could use a cup independently and that his hand feeding skills were good. She noted some tactile defensiveness, however.

At the end of the evaluation we heard Jan's concerns about David's health, overall development, and fussiness about eating. Her exasperation and fear were clear. We also had a chance to discuss our own observations.

We told her that children of David's age often like to experiment with feeding themselves, that they often have a small appetite, and that perhaps David needed more time to eat in his own way. In addition we explained that children with tactile defensiveness need extra time to get used to new textures. We also stressed that children of David's age are prone to power struggles, and that it is very tempting for parents to get caught up in their concern for the quantity of intake, particularly when the child is underweight, delayed, or unhealthy.

We suggested that Jan stop spoon-feeding for now and instead offer a small choice of crunchy finger foods, which promote oral motor control and lessen drooling. We also suggested that she busy herself around the kitchen while he was eating, and try to relax about the mess. Furthermore, we stressed to Jan that David did eat, and that we saw him eat, and that his cup skills were excellent. We invited Jan to bring David to the Feeding Support Group, which was starting a series of sessions in a few weeks.

David and Jan attended two eight week series of Feeding Support Group sessions over a six-month period. As Jan relaxed, she was able to adapt to David's need for extra time for, and control over, his eating.

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As David felt more independent, his self-feeding skills and pleasure in eating increased. Feeding and eating were no longer a battle zone.

Jan was a very active and vocal member of the group. She learned to set reasonable goals, her primary one being to encourage David's independent feeding skills. She listened to and absorbed information, and she used suggestions. She could talk about both progress and difficulties. One trying experience occurred when elective surgery was called off because David was found to be anemic. Jan felt accused by the surgeon's comment that she simply was "not feeding her child enough" and suggestion that she force feed David.

Jan was able to listen to, support, and form relationships with the other members of the group. The most dramatic moment of Jan's participation in the group was during an experimental role-play. We had asked that each member pretend to be her own child and experience being fed by one of the other mothers. As the pairs took turns, the mother who was going to feed Jan was finishing feeding someone else. She got the food ready for Jan but then turned away for a few moments, distracted by her own child. Suddenly she proclaimed, "Oh my goodness, I forgot all about you!" and turned, embarrassed to Jan. Jan, meanwhile, had started to eat and was busily eating, having forgotten that someone was supposed to feed her. Both mothers were very amused at the result of this experience. When invited to reflect on what she learned from it, Jan said that she realized that David was very capable of feeding himself and that perhaps he did best when attention was not focused directly on him while he was eating.

David also made many changes during his participation in the group. His skills with spoon, cup and fork increased. He became able to enjoy a wider variety of foods. He learned that he could assert himself, feel successful, and even have fun while eating.

For David's family, the final payoff was that David began steadily to gain weight.

David also made marked progress in other areas of development during his involvement with our program. At a family conference four months after he and his mother joined the Feeding Support Group, the staff members who had been providing ongoing therapy noticed that David was less fearful and more willing to take risks motorically. Although a delay of six months in expressive language had been identified, David was exhibiting growth. He was described as the "star" of the feeding group. David's promotion to the program's Toddler Group represented to his family concrete evidence of his progress.

As David's mother so succinctly stated at her last meeting of the Feeding Group, "I learned a new perspective. There are lots of different types of problems; I learned that I was not alone. I learned that other mothers worry about their children's eating. I learned to relax." As Jan learned these important lessons, she was able to give David the patience and freedom to develop his feeding skills and his sense of himself as an increasingly independent and competent person. The Feeding Support Group provide a safe environment for Jan and David to learn about, and try, new ways of feeding, eating, and relating.

Perspectives on Practice

Parent Training from the Speech-Language Pathologist's Perspective: A Case Study

by

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With the passage of Education for the Handicapped Act Amendments of 1986, P.L. 99-457, and the ever increasing focus on early interevention services for children with disabilities, the potential role of a speech-language pathologist as a parent trainer has increased dramatically. This changing role is examined by describing The Kennedy Institute's Child and Family Support Program, delineating the role of the speech-language pathologist in this program and presenting a case history.

Program description

The Child and Family Support Program of The Kennedy Institute, Baltimore, Maryland provides in-home parent training and counseling to families whose child with a developmental disability is between the ages of birth and seven. Services are provided through a transdisciplinary team which includes an occupational therapist, physical therapist, speech pathologist, nurse, nutritionist, educators and social workers. In addition to in-home services, all families are encouraged to participate in educational and supportive counseling groups as well as to utilize a toy, book and equipment lending library.

Program components: The impact on the speech-language pathologist's role

There are several components of this program which impact on the role of the speech-language pathologist. First, the **home-based** nature of the program allows the speech-language pathologist to adapt interventions to the family's routines, train extended family members and provide early identification of speech and language delays in siblings. A number of researchers (Helm and Kozloff, 1986; Wulz, et. al., 1983; and Fitzgerald and Karneo, 1987) have documented the importance of the home setting in achieving these goals.

Second, the **parent directed** focus of the program allows parents to choose which of the available services they wish to receive. Mueller and Leviton (1986), have identified the importance of this approach, which encourages parents, as opposed to therapists, to be the primary agents in identifying the goals for intervention and determining the frequency of visits.

Finally, in this **parent-training** model, the speech-language pathologist works primarily with the parent, who then utilizes this training to encourage the child's speech and language development. The effectiveness of having parents assume the role of primary change agent in meeting their children's therapeutic needs is illustrated by McDade and Varnedoe (1987).

Parent training by the Child and Family Support Program's speech-language pathologist includes three modes of intervention:

1) When a child is diagnosed with speech and language delays and the most effective means of intervention is determined to be direct speech and language therapy from a school or clinic, the speech-language pathologist coordinates home-based parent training with direct therapy services in order to maintain a consistent approach.

2) When a child is diagnosed with speech and language delays and parent training is determined to be the most effective means of intervention, the speech-language pathologist provides activities and suggestions to assist the parents in enhancing their child's language skills.

3) When a child is at risk for developing speech/language delays and is in need of monitoring services only, the speech-language pathologist provides information to the parents regarding normal developmental milestones as well as warning signs which might indicate the need for further intervention.

Williams (1986), describes the need for the speech pathologist to provide family support in many ways. In all three of the above mentioned modes of intervention, the speech-language pathologist supports families by acting as a non-judgmental listener, jointly attending agency meetings as a family advocate and identifying and coordinating community resources at the parent's request. The variety of roles assumed by the speech-language pathologist in this program will be further illustrated in the following case study.

Family background

The Michaels' family consists of Mr. and Mrs. Michaels, Tom, aged 26 months, and a newborn baby sister, Ellen. Tom was diagnosed with speech and language delays, as well as suspected overall developmental delays. Mrs. Michaels was referred to the Child and Family Support Program by a co-worker whose family was also receiving services from the program. Both parents were employed full-time outside the home and the children were cared for during the day by a sitter in the Michaels' home.

Initital home visit

The speech-language pathologist and parent educator met with the family for an initial home visit to describe the program and to explore the family's interest in participation. In addition to discussing the major aspects

of the program (i.e., home-based service delivery from a transdisciplinary team, parent training within a parent-directed model, etc.), the therapists outlined an approach to assist Tom's overall speech and language development. Because of the Michaels' work schedules, they decided that bi-weekly visits in the early evening would most appropriately meet their needs.

Speech-language pathologist's parent training

Following the initial visit, the speech-language pathologist met with the family on a bi-weekly basis to complete Tom's assessment and to initiate speech and language interventions. The primary mode of intervention included the use of play activities which could be incorporated into the family's daily routines. The speech-pathologist began each session by demonstrating play activities to train the Michaels in communication enhancing skills that could be integrated into their everyday interactions. The Michaels were then given an opportunity to practice each of these interventions, while under observation, in order to refine their skills in implementing these activities.

A good example of incorporating play activities into daily routines occurred during Tom's bathtime. The familiar game of "identifying body parts" was transformed into a three-part activity to address three important areas of speech and language development. During Tom's bath, he was asked to name a part of his body that he would like to wash as a way of encouraging expressive or spoken language development. If Tom said "arm", he was then asked to point to his arm which helped Tom develop receptive language or comprehension of the meaning of words. Following this activity, Tom and his parents would make up a rhyming song using the word "arm" (e.g., "Look who's on the farm. It's Tom's warm arm."). This activity helped to improve Tom's ability to articulate words more clearly.

With the use of activities such as these, not only did Tom's articulation skills improve but his parents enjoyed the process and felt more comfortable in communicating with their son. In addition, the Michaels felt that Tom's daily routines (i.e., mealtime, bath, etc.) went more smoothly and were less time consuming due to his increased ability to communicate.

Training of extended family and other caregivers

An additional function of the Child and Family Support Program is to provide training to extended family members and other caregivers, at the request of the parents. The Michaels family requested training for both Tom's grandparents and his day care provider, Mrs. Hamilton.

Tom's grandparents requested help in understanding Tom's diagnosis and its implications for future programming. The speech-language pathologist provided his grandparents with literature regarding speech and language development and described Tom's speech and language delay in functional terms with practical suggestions to improve their ability to communicate with him. In addition, information was provided about the range of school programs and direct speech and language therapy options that would be available to assist with Tom's speech and language development.

A meeting with Tom's day care provider, Mrs. Hamilton, revealed that she interacted well with Tom, but was concerned about his frustration at not being understood. The speech-language pathologist provided several suggestions and play activities to address this concern. Mrs. Hamilton found that utilizing a question and answer game with yes/no questions increased Tom's willingness to clarify his comments and appeared to lessen his frustration at not being understood.

Subsequent visits with the Michaels confirmed that the suggestions had been helpful in improving both the grandparents' and Mrs. Hamilton's ability to understand and interact with Tom. Parents, such as the Michaels, have found that direct communication between professionals and extended family members, as well as other caregivers, often prevents parents from having to assume the difficult role of acting as the intermediary between professionals' perspectives and family viewpoints.

Transdisciplinary use of consultation

When providing services to families such as the Michaels, the primary therapist must often make use of the knowledge and expertise of other disciplines represented on the team. The Child and Family Support Program employs a transdisciplinary model in which a professional from one discipline serves as the primary therapist based on the families' needs, with the other disciplines available to serve on a consultation basis in roles which may vary from direct service to families, to performing in an advisory capacity to the primary therapist.

Since the primary concerns of the Michaels family related to Tom's speech and language development, the speech-language pathologist was designated as the primary therapist. During the Michaels' involvement with the program, the speech-language pathologist and the parents identified two areas which necessitated consultation with other disciplines: Tom's drooling and his need for educational placement.

The Michaels expressed concern regarding Tom's frequent drooling. The speech-language pathologist conferred with the team's occupational therapist who suggested age appropriate activities which would improve the tone of the lips and thereby inhibit drooling. The speech-language pathologist suggested activities such as blowing and sucking through straws, sucking on lemon sticks, and blowing bubbles, which could be incorporated into the family's daily feeding and play routines. Following these interventions, the Michaels notice a significant decrease in Tom's drooling.

When Tom reached the age of three, the Michaels felt that their son would benefit from interaction with other children in a school setting. The speech-language pathologist suggested that the Michaels meet with the team educator to explore options for Tom's school placement. The educator visited the Michaels' home to observe Tom's play behaviors and to complete an informal assessment of his cognitive skills. During these visits the educator spoke with the Michaels to explore their priorities in the selection of a school placement for Tom. The educator then met with the Michaels and the speech-language pathologist to provide recommendations for public and private school programs which she felt could optimally address Tom's social, emotional, and intellectual needs.

In order to follow through on these recommendations, the speech-language pathologist and the Michaels visited several school programs and chose to enter Tom in a private neighborhood nursery school program. The speech-language pathologist met with Tom's teacher both prior to his entry into school and throughout the school year in order to assist her in utilizing techniques in the classroom that would promote Tom's articulation and language development.

Transitioning from program

The speech-language pathologist provided services to the Michaels family over an eighteen month period. In the last few months of service, both the Michaels and the speech-language pathologist felt that their goals had been achieved and they began to plan for the family's transition from the program. The Michaels felt that Tom had made significant progress in his ability to communicate more clearly and was no longer as frustrated in expressing his needs. In addition, the Michaels believed that they had learned effective techniques for increasing Tom's communication skills that could be generalized to a variety of situations.

The speech-language pathologist and the family also completed a review of professionals who were currently providing services to Tom (i.e., nursery school teacher, primary pediatrician) and identified potential resources that could be utilized should future needs emerge. The speech-language pathologist, with the Michaels' permission, contacted Tom's teacher and pediatrician to discuss Tom's transition from the Child and Family Support Program. During these converstations, the speech-language pathologist encouraged the teacher and the doctor to continue to monitor Tom's speech and language development over the next few years in order to make referrals to available community resources should interventions be necessary.

Conclusion

This case study illustrates the variety of potential roles available to speech-language pathologists and other therapists in providing early intervention services to children and their families. Many elements of the model illustrated in this case study can be incorporated into service delivery systems that are either clinic or school based, as well as child focused. The elements that potentially can be generalized to other programs include:

1) A transdisciplinary model of service delivery
2) A parent training focus
3) An emphasis on the training of extended family and other caregivers
4) A home based service delivery component
5) An effort to incorporate therapeutic activities into daily routines
6) A commitment to parent determination of type and frequency of program interventions

The importance of working "with and through" the family to service children who are developmentally disabled has been well established (see Wolfensberger and Menolascino, 1970). Program directors, clinicians, and families now need to explore ways to implement elements of a family centered approach into their current service delivery system.

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National Center Notes

by Eleanor S. Szanton

For the first time in our nation's history almost 60 percent of mothers of children under age three are working outside their homes. Yet we do not know as much as we should about the quality of care their infants and toddlers are receiving. We do know:

- Only three states have requirements for an adult: child ratio in child care that matches the standards recommended but never adopted by the federal government in 1980. These ratios are 1:3 for children under two years of age and 1:4 for children between 2-3 years of age.

- The majority of children under age three are in family day care. Yet the overwhelming majority of this care is unregistered and unregulated. Some of it is excellent, some actually harmful. The point is, we have very little way of finding out which is which and helping to improve those programs which need help.

- On average, infant day care providers have less than a high school education, with no formal training in child care or child development.

- It is estimated that there is a turnover rate of as much as 40% per year among day care providers.

At the same time, researchers who are examining both developmental outcomes of infants in day care as well as parental discomfort are raising disquieting questions about what they are finding. (See *Zero to Three* Special Reprint, September, 1987, and *Infants, Families and Child Care: Toward a Research Agenda*, NCCIP, 1988.)

Now some new developments, both reassuring and disquieting, are taking place in the public policy arena concerning infant day care:

- The National Institute for Child Health and Human Development (NICHD) is funding a large-scale multi-site research effort to ascertain the impact of infant day care on the emotional, social and cognitive development of children. Designed to examine children over a period of years, in various child care settings and coming from various demographic environments, the study, if sufficiently funded, should go far toward answering some of the questions presently raised by those who question the effects of child care on very young children. NCCIP takes pride in the fact that this NICHD initiative came upon the heels of an NCCIP-sponsored "summit meeting" of infant day care researchers which laid out areas of agreement about what was already known about the effect of day care on infants and suggested promising lines of future research. The recommendations of that meeting were used by NICHD in designing its request for proposals.

- A number of states are taking a fresh look at their standards for infant (center-based and family) day care and are seeking new ways to provide training and technical assistance to infant day care providers whose programs they monitor. For example, the state of California has launched an innovative training program for infant-toddler caregivers, using video. Similarly, the state of New Jersey has made a substantial commitment to providing training through videos to family day care providers through resource and referral networks.

NCCIP is pleased to announce that it has received a grant from the Ford Foundation to work with all states, and more intensively with a few, in seeking ways to more successfully monitor and provide technical assistance to infant care programs within their jurisdictions. Entitled "Better Care for the Babies," the program will give assistance particularly in the areas of health and developmental screening and monitoring and in training of infant care providers.

At the same time, infant care specialists are concerned about present and/or future initiatives being undertaken by the federal government to expand the quantity and quality of day care for infants. One such proposal, the Working Family Child Care Assistance Act of 1989, introduced by Senator Robert Dole at the request of President Bush, is designed to put more money in the hands of low-income working parents of children under 4, either to spend on child care or to allow mothers to stay home with their young children. While children's allowances themselves may be a valuable component of family policies, $1,000 per child does not offer enough assistance either to pay for quality child care or to substitute for a salary. Nor does it improve training, technical assistance, or monitoring of child care programs.

The Act for Better Child Care (ABC), the principles of which have been supported by a large number of legislators and child advocates (including NCCIP), would go much farther than the administration's proposal toward (1) increasing the supply of quality child care; (2) enhancing the ability of low and middle income parents to pay for it; (3) supporting the establishment of programs to train child care workers; and (4) establishing a reasonable schedule for nationwide minimum standards for child care. The bill recognizes that high quality infant care is necessarily more expensive than the care of older children. Certain concerns about church-state relationships remain to be fully resolved.

Another major initiative, H.R. 3, introduced by Congressman Augustus Hawkins, seeks specifically to increase the supply of infant day care, while expanding child care for older children through the schools and the Head Start program. NCCIP has prepared an extensive analysis of this bill which is available on request.

Finally, NCCIP remains very concerned about the effect of the Family Support Act of 1988 (welfare reform) on child care for infants and toddlers. The Act requires states to insist that all children (including infants) of parents under the age of 20 who have not yet finished high school be put in day care while their parents pursue education activities. It also allows states to require mothers of children twelve months and older to put their children in day care, while reimbursing them far less than would be required to pay for high quality care. The effect of this, again before the passage of federal minimum standards for child care, may put welfare reformers on a collision course with those who are seeking to improve the daily care of some of our nation's neediest infants and toddlers.

Infants and toddlers are undoubtedly more vulnerable to noxious environmental circumstances than are older children; national attention to the circumstances of their daily care is essential. At the same time, high quality child care, well integrated with other preventive health, developmental screening, child abuse, and early intervention initiatives, shows great promise of providing an important foundation for later development. Those who understand the specifics of infant development have an obligation to acquaint policymakers at every level with the opportunities provided by high quality child care to strengthen young children and their families and the dangers of continued neglect.

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NCCIP is pleased to announce that *Edward Zigler*, Sterling Professor of Psychology at Yale University and Chairman of the Bush Center for Child Development and Social Policy, is recipient of this year's Ittleson Award, presented by the American Orthopsychiatric Association. Dr. Zigler has served for a number of years on the Board of NCCIP and has been a constant inspiration to NCCIP's activities in the area of infant and toddler day care.

Help Wanted

The **Bush Center in Child Development and Social Policy** in conjunction with the National Council of Jewish Women is developing a National Family Day Care Project resource clearinghouse. Readers who know of any materials that would be an interesting and useful resource to a family day care provider are invited to send information to Dr. Matia Finn-Stevenson, The Bush Center in Child Development and Social Policy, Yale University, P.O. Box 11A, Yale Station, New Haven, CT 06520-7447.

Letter to the Editors

We would like to express our congratulations for the excellent articles included on infant pain in the December, 1988 issue of *Zero to Three*. Pain is an area that is seriously neglected in the care of infants and young children. We believe that health professionals' reluctance to use analgesics and anesthetics is partly related to a lack of appreciation of the signs of pain in children. In our experience, a multidimensional approach has been helpful in presenting a more complete picture of pain assessment. We have called this process **QUEST** for **Q**uestioning the child; **U**sing pain rating scales; **E**valuating behavior; **S**ecuring parents' involvement; and **T**aking the cause of the pain into account.

Asking children about their pain is useful with verbal children. Children as young as 2 years of age can tell us about their pain if asked using familiar words, such as "booboo" or "owie." Asking them to locate pain by pointing to where it hurts with one finger or to "where Mommy or Daddy would put a bandaid" is helpful.

Several pain rating scales have been developed that provide a quantitative measure of pain, but most are designed for children of school age. One that shows promise for young children consists of a series of cartoon or photographic faces. We have developed a cartoon faces scale that can be used with children about 3 years of age. The faces scale is available from the Purdue Frederick Company by calling 1-800-243-5007, extension 4025.

Observing behavioral changes is an important clue to pain in infants and young children. A facial expression of distress—brows lowered and drawn together, eyes tightly closed, and mouth open and squarish—usually combined with a loud cry is a cardinal sign of pain. Other behavioral responses are irritability, lethargy, loss of appetite, unusual quietness, disturbed sleep patterns, increased restless movement or rigid posturing, flat affect, or anger. Specific reactions often indicate discomfort in localized body regions—such as rolling the head from side to side for a headache, pulling the ears for an earache, or lying on the side with legs flexed on the abdomen for a stomachache.

The child's response to medication is another valuable indicator of pain. For example, in preverbal children who communicate a wide variety of emotions through behavior, obvious change in behavior following administration of an analgesic is evidence of pain.

Many people rely on physiologic responses, such as flushing of the skin, increase in sweating, blood pressure, pulse and respiration, restlessness, and dilation of the pupils, before they believe that a child is hurting. However, these signs are very variable, may be produced by emotions, such as fear, anger, or anxiety, and occur primarily in acute pain. Consequently, they can be unreliable signals of pain.

An area that we believe is neglected is including parents in pain assessment. Parents know their child and are sensitive to changes in behavior. Unfortunately, there is no documentation of exactly how astute parents are in recognizing pain in their children. Some parents may never have seen their child in severe pain. However, others are aware that certain behaviors signal pain because of past experiences. To better assess the pain, we should interview parents about their child's previous pain behaviors and encourage their participation in assessing their child's current pain.

Lastly, we should take the cause of pain into account when assessing an infant's discomfort. If we consider a procedure, such as circumcision, to be painful to an adult, then we should expect the infant to experience pain also.

We hope that with increased awareness of pain in infants and young children combined with knowledge of ways to assess and control their pain that we will prevent our children from suffering needlessly.

Sincerely,

Donna Wong

Donna Wong, RN, MN, PNP
Oklahoma City, Oklahoma

Connie Baker

Connie Baker, MS
Tulsa, Oklahoma

Publications

Giving Children A Chance: The Case for More Effective National Policies (1989)—George Miller, editor (Center for National Policy Press, Washington, D.C. Distributed by UPA, Inc. 4720 Boston Way, Lanham, MD 20706) $26.50 hardcover, $15 paper.

"The devastating effect of poverty is not only that it directly and chronically threatens infants' physical well-being from the time they are conceived, it also undermines the capacity and resources of their parents to protect, nurture and guide them . . . In some, perhaps a good many instances, we must first undo damage already done before we can begin to promote skills or educate parents. Strengths must be built *in* before they can be built *on*." These words come from the chapter by Judith Musick and Robert Halpern, and suggest some of the themes and concepts that run through this publication, a part of a Center for National Policy project called "Investing in Prevention."

In an introduction by Congressman George Miller and in chapters by Bernice Weissbourd and Carol Emig, James Garbarino, Eleanor Stokes Szanton, Sara Rosenbaum, James Comer, Stanley Greenspan, Lisbeth Bamberger Schorr, and Judith Musick and Robert Halpern and in an Appendix by Peter D. Hart, data on children's health, welfare and development are presented. In addition, the experiences of multiply stressed families are analyzed with particular attention to the conditions that create an underclass. Effective interventions are seen as paying attention to relationships (whether between parent and child or among parent, child and service providers), as dependent upon appropriately trained staff, and as all too vulnerable to a "demonstration-dilution" effect, in which exemplary model programs decline in quality if levels of funding, small caseloads, and skilled staff are not maintained.

The Vulnerable (1988)—John L. Palmer and Isabel V. Sawhill, editors (The Urban Institute Press, 4720 Boston Way, Lanham, MD 20706) $36.50 hardcover; $18.75 paper.

This book, part of the Urban Institutes Changing Domestic Priorities series, focuses on changes in material well-being among children and the elderly, the nation's two largest dependent groups. Economic conditions, demographic change, and public policy are examined as major determinants of material well-being, and the experience of the United States over the past 40 years is compared with trends in Japan and Sweden. The findings in this volume that have been reported in the general media include the observations that beginning in the 1970's, the economic status of the aged has continued to improve while the status of children has generally deteriorated and that children in the United States have much higher poverty rates than their counterparts in other countries with more or less equivalent overall standards of living.

With regards to children's poverty, authors note that:

- Children's economic status depends less on age per se than on race and family composition and exposure to events such as parental unemployment, divorce, illness and death in the family.
- The lack of growth in earnings since the 1970's accounts for almost all the overall stagnation in the real incomes of families with children.
- With the major exception of public education for children, most benefits for children such as income, housing and food stamps must pass through parents, and "Americans have historically been wary of transferring public resources to able-bodied adults."

The Changing American Family and Public Policy (1988)—Andrew J. Cherlin, editor (Urban Institute Press, 4720 Boston Way, Lanham, MD 20706) $15.95 paper.

The emphasis of this volume, part of the Urban Institute's Changing Domestic Priority Series, is, according to its editors, on encouraging a broad understanding of the consequences of social change and their relationship to public policy, rather than on endorsing specific programs. Thus Andrew Cherlin, Nicholas Zill, Frank Furstenberg, Cynthia Fuchs Epstein, Mary Jo Bane and their colleagues examine changes in family structures, roles of mothers and fathers, government policy, and trends in the indicators of children's well-being. Nicholas Zill concludes that "the family is changing, not disintegrating; trends in children's well-being have been mixed, with deterioration in some areas but stability and even improvement in others; and the links between family trends and trends in children's well-being are weaker than commonly supposed." Mary Jo Bane and Paul Jargowsky suggest that government policies have not contributed substantially to trends in family *structure* and that no government policy will reverse the increase in the proportion of children in female-headed families. They argue for attacking the problem of poverty among children directly through policies that invest in children and support the families in which they live—e.g., education, including preschool education; health care; child support enforcement; child care and parental leave; and welfare reform.

Black Children and American Institutions: An Ecological Review and Resource Guide (1988)—Valora Washington and Velma LaPoint (Garland Publishing, Inc., 136 Madison Avenue, New York, NY 10000) $64.00.

Black children represent the majority of all nonwhite American children, comprise over one third of all black Americans and are projected to increase in numbers more than 20 percent over the next decade. The authors of this volume note that the unique history of the black population in this country has meant that black children, more than any other group, have been affected by social policy and public institutions. This "ecological review" of the interaction of black children with American institutions looks at the family, schools, social services, child welfare, the criminal justice system, and physical and mental health services. Developed as a reference tool, the book contains brief essays followed by an annotated bibliography and a list of national organizations which advocate for and promote the development of black children.

The Transition to Parenthood: Current Theory and Research (1988)—Gerald Michaels and Wendy Goldberg (Cambridge University Press, 510 North Avenue, New Rochelle, NY 10801) $39.50

The transition to parenthood refers to the period of time from the beginning of a pregnancy through the first months of having a child. The editors of this volume suggest that this transition may be the most universally occurring adult developmental transition, with psychological, sociocultural, and biological components, all of which interact and influence one another. The ten chapters of this volume address the transition to parenthood as a challenge for adaptation by individuals, couples and families; the transition to parenthood under conditions of biological and environmental risk; and intervention strategies. The editors have organized a compendium of the key factors that seem to be antecedents and correlates of adaptation or maladaptation during the transition to parenthood as well as formal and informal intervention strategies that can assist mothers and fathers in the pre-conception, pregnancy and postnatal phases of the transition period. Contributors to the volume include Toni Antonucci, Carolyn Pape Cowan, Philip A. Cowan, Martha Ourieff Diamond, S. Wayne Duncan, M. Ann Easterbrooks, Nicolina Fedele, Wendy Goldberg, Ellen Golding, Benjamin Gottlieb, Frances Grossman, Linda Hughey Holt, Sharon L. Kagan, Howard Markman, Gerald Michaels, Karen Mikus, Howard Osofsky, Joy Osofsky, S. Mark Pancer, William Pollack and Victoria Seitz.

Men's Transition to Parenthood: Longitudinal Studies of Early Family Experience (1987)—Phyllis W. Berman and Frank A. Pedersen, editors (Lawrence Erlbaum Associates, Inc., Suite 102, 365 Broadway, Hillsdale, NJ 07642) $29.95

This book presents the work of eight investigators who participated in a 1984 conference organized by the National Institute of Child Health and Human Development to explore theoretical and methodological questions concerning men's development of parental attitudes, behaviors and roles from their children's prenatal period through early infancy. While earlier phases of research looked at fathers as markers of socioeconomic status, studied the impact of father-absence, or correlated father and child characteristics, more recent research studies, including those in this volume, attend more to individual differences in paternal adaptation, include longitudinal assessments, and view paternal adaptations within the context of other family members and other relationships, including the marital relationship. Several contributors address the theme of emotional support, finding that fathers seems to be in particular need of support in the parenting role, depending on marriage relationships and their wives' expectations to define and model the paternal role. In exploring the strains of new parenthood, investigators found that there is often great discrepancy between fathers' expectations of parenthood and their real experience. More father participation in childrearing may be at a cost to the marital relationship, particularly when little social support for father participation is available. Researchers also stressed the need to understand change occurring over time (including the addition of a second child) and the contribution of infant characteristics. Contributors to the volume include Frank Pedersen, S. Shirley Feldman, Jay Belsky, Frances Kaplan Grossman, Jane Dickie, Carolyn Pape Cowan and Philip A. Cowan, Michael Yogman, Ross D. Parke, Phyllis Berman, and their colleagues.

The Different Faces of Motherhood (1988)—Beverly Birns and Dale Hay (Plenum Press, 233 Spring Street, New York, NY 10013) $35.00.

The purpose of this volume as described by the editors, who met with authors to establish goals and research methods, is to examine how different groups of mothers lead their lives. Authors were asked to focus on mothers in their own right, not simply as influences on child development. Mothers were looked at in the context of their more general life experiences; authors were also asked to explore not just the objective status of mothers and their children but what mothers themselves had to say in direct interviews. Themes that recur throughout the book concern: 1) the tension between theory and practice (what mothers are told they should do as opposed to what they do do); 2) the need to pay attention to historical and social context; and 3) the dilemmas posed by rapid worldwide social change. The volume includes a review of some influential theories of the mother-child relationship; examinations of motherhood in China, Morocco and the Netherlands; and issues confronting mothers in the work force, black mothers, divorced mothers, mothers who are disabled and older mothers in America.

Feminism, Children and the New Families (1988)—Sanford M. Dornbusch and Myra H. Strober, editors (The Guilford Press, 72 Spring Street, New York, NY 10012) $40 hardcover; $18.95 paper.

"We want to complicate the public policy questions," declare the editors of this volume, "both by making feminists think about children's needs and by making those concerned with children think about feminist issues." This book is an outgrowth of a Ford Foundation-supported project which assembled a group of scholars from the faculty of Stanford University and visitors to the campus to explore public policy implications of perceived conflicts between children's interests and feminists' interests. Chapters in the first part of the book address the relation between feminist ideology and the functions of families—issues, for example, of sex roles, the interests of children and feminists in child care, and the role of the state in institutionalizing relations between women and children. (The issues that truly divide feminists from the traditional right, two authors suggest, are about *adult roles* rather than *children's needs*). The second section of the book discusses "the new families," including two-earner families, divorced families, single-parent families and step-families. Policy recommendations that emerge from the 12 essays are grouped into three categories: 1) enabling young people and adults to perform nontraditional tasks more effectively at home and at work; 2) developing new arrangements for child care; and 3) assisting in difficult transitions after divorce.

Maternal Employment and Children's Development: Longitudinal Research (1988)—Adele Eskeles Gottfried and Allen W. Gottfried, editors (Plenum Press, 233 Spring Street, New York, NY 10013) $34.50.

The editors describe the purpose of this volume as the provision of a comprehensive analysis and integration of findings concerning the role of maternal employment in children's development based exclusively on longitudinal research. The studies examine developmental trends concerning the effects of maternal employment status on children from three months of age through adolescence and examine an extensive array of developmental domains. The studies, all conducted in "a wide range" of middle-class families, also pay attention to the role of home environment, mothers' attitudes, contemporaneous and long-term effects, hours of employment and conditions of the workspace, children's genders, and other variables. Social policy recommendations include "stable, quality child care from infancy through childhood;" conditions of employment more responsive to parenting responsibilities; and maternity policies to facilitate mothers' transition into the work force and protect their rights. Among the contributors to the volume are Jacqueline Lerner, Margaret Treasch Owen, Wendy A. Goldberg, Ellen Hock, Debra DeMeis, Susan McBride, Ellen Galinsky, Diane Hughes, Adele Eskeles Gottfried and Allen W. Gottfried.

Policy Implementation and P.L. 99-457 (1989)—James J. Gallagher, Pascal L. Trohanis and Richard M. Clifford, editors (Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, MD 21285-0624) $28.00 paper.

Many of the 11 chapters in this volume were originally papers presented at a spring, 1987 conference sponsored by the Bush Foundation, The North Carolina Department of Public Instruction and entities within the University of North Carolina at Chapel Hill. The issues addressed include the lessons to be learned from implementing P.L. 99-457, the implications of the law's family-centered approach, personnel preparation, interagency planning, financing, and the use of outcome measures. An introduction to P.L. 99-457 is included, and a seven-stage model for analyzing the implementation of the law is suggested. Contributors to the volume include Donald Bailey, Richard Clifford, Paul Dokecki, Harriette Fox, Steve Freedman, James Gallagher, Craig Anne Heflinger, Oliver Leon Hurley, Brian Klepper, Duncan MacRae, Edward Martin, Brian McNulty, Pascal Trohanis, Margaret Wang and Martha Ziegler.

Four Critical Junctures: Support for Parents of Children with Special Needs (1989)—Elsie Edge and Peggy Pizzo, editors (National Center for Clinical Infant Programs, Washington, D.C. Available free of charge through Office of Maternal and Child Health grant #113271 from National Center for Education in Maternal and Child Health, 38th and R Streets, N.W., Washington, D.C. 20057.)

This pamphlet contains recommendations that represent the consensus of many parents of children with special health needs who are associated with NCCIP's Project Zero to Three. These recommendations to professionals are designed to ease families' passage through: 1) The birth or adoption of a child with special needs or the later onset, recognition, or diagnosis of special needs; 2) discharge from the hospital to home; 3) entry into early intervention services; and 4) transition from one program to the next.

Conference Call

May, 1989

May 17-18, June 22-23: The *Young Adult Institute* will offer two two-day workshops in New York City for group facilitators working with the parents of infants and young children with developmental disabilities. Entitled "Working Effectively with Families: a comprehensive training program for parents and young children with developmental disabilities," the workshops use YAI's "Children with Special Needs" video series. For information, contact Jordana Zeger, YAI, 460 West 34th Street, New York, NY 10001-2382, tel: (212) 563-7474.

May 20: *The Jefferson Medical College* and *The Philadelphia Psychoanalytic Society and Institute* will hold the 20th annual Margaret S. Mahler Symposium in Philadelphia, Pennsylvania on the topic "New Considerations on Issues of Individuation." Speakers will be Elsa Blum, Harold Blum, T. Berry Brazelton and Robert N. Emde. For information, contact Gloria Schwartz, 1015 Chestnut Street, 2nd Floor, Philadelphia, PA 19107.

May 22-26: The *C. Henry Kempe National Center for Prevention and Treatment of Child Abuse and Neglect* and the *Department of Pediatrics, University of Colorado Health Sciences Center* will present the eighteenth annual Child Abuse and Neglect Symposium in Keystone, Colorado. Plenary addresses, seminars and case presentations will address healthy and unhealthy attachments, clinical and system intervention approaches, and legal management of child abuse, among other issues. Faculty will include members of the Kempe Center faculty and guest presenters. For further information contact Marilyn Lenherr, Training Administrator, Kempe Center, 1205 Oneida Street, Denver, Colorado 80220, tel: (303) 321-3963.

May 28-31: The *Association for the Care of Children's Health* will hold its 24th annual conference in Anaheim, California with the theme "Family Centered Care: Making It a Reality." Plenary speakers will include Judith Weitz, Patricia Smith, Mary Cerreto, Elizebeth Crocker, Corinne Barnes, Dolores Wilder, and Michael Weitzman. Write or call ACCH Annual Conference, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016, tel: (202) 244-1801.

June, 1989

June 8-12: The National Conference of State Legislatures will sponsor a National Issues Seminar in Nashville, Tennessee on the topic "Financing Human Services." Sessions will address welfare reform, health care for pregnant women and young children, options for special needs children, cost containment programs, and financing teen pregnancy programs, among other issues. Contact NCSL, Seminars Department, 1050 17th Street, Suite 2100, Denver, CO 80265.

June 9-10: The *Department of Special Education, Teachers College, Columbia University* will sponsor a training workshop in New York City entitled "Assessment and the Development of Individualized Family Service Plans for Infants with Disabilities and Their Families." Faculty will be Kay Ferrell and Theresa Bologna. For information, contact Professor Ferrell, Box 223, Teachers College, Columbia University, New York, NY 10027.

June 12-16: The *College for Human Development, Syracuse University* will hold its 13th annual Quality Infant/Toddler Caregiving Workshop in Syracuse, New York. Led by Alice Honig, the workshop offers information on infant development and practical training in infant caregiving. Contact Pat Martin, Department of Child and Family Studies, Syracuse University, 201 Slocum Hall, Syracuse, NY 13244-1250.

June 18-23: The third annual *Frank Porter Graham Summer Leadership Institute* will be held at the University of North Carolina, Chapel Hill. The Institute will address issues of supervision, evaluation and research in infant/toddler, preschool and home visiting programs. Faculty will include Richard Clifford, Thelma Harms, Barbara Wasik, James Gallagher and C. Arden Miller. For program information, contact Isabelle Lewis, FPG Summer Leadership Institute, CB #8040, Suite 300 NCNB Plaza, UNC-Chapel Hill, Chapel Hill, NC 27599-8040, tel: (919) 962-7376.

June 21-24: *Bank Street College* will hold its second annual Infancy Institute, entitled "Infants, Toddlers, Parents: Supporting Their Growth," in New York City, with Alice Honig as keynote speaker. The institute will include visits to infant/toddler programs, video presentations, individual consultations and workshops. Contact Nancy Balaban, Infant and Parent Development Program, Graduate School of Education, Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 663-7200.

June 23-25: The *International Childbirth Education Association* will hold its 1989 International Convention in Minneapolis, Minnesota. For information contact ICEA, P.O. Box 20048, Minneapolis, MN 55420.

July, 1989

July 6-8: The *Human Services Research Institute* and *United Cerebral Palsy Associations* will sponsor a conference in Cambridge, Massachusetts entitled "Celebrating the Family: Enhancing the Lives of Children with Chronic Illnesses and Disabilities." Speakers include Ann Turnbull, Addie Comegys, Hank Bersani, Sharmin Jamison, Allen Crocker, Margaret Mikol, Nancy Rosenau, Elaine Ostroff, Mary Beth Bruder and Barbara Friessen. For information call Sara Bedford, Conference Coordinator, HSRI, tel: (617) 876-0426.

July 6-8: *Contemporary Forums* will hold a conference in New York City on neurological issues in infant and early child development. Contact Contemporary Forums, 530 LaGonda Way, Suite E, Danville, CA 95426, tel: (415) 820-2800.

July 16-21: The University of Northern Colorado will sponsor a symposium in Breckinridge, Colorado entitled

"Special Needs Preschoolers and Infants: Applied Programming and Instruction." Faculty will include John Neisworth, Stephen Bagnato, Sandra Mlinarcik, Tom Shea, Donna Bottenberg, Thomas Sileo, Ann Sileo, and Allen Huang. For information contact Sandy Bitter Kephart Memorial Child Study Center, Division of Special Education, University of Northern Colorado, Greeley, CO 80639, tel: (303) 351-2306.

July 19-21: The *Family Resource Coalition* will hold a 1989 Summer Training Institute at DePaul University in Chicago, Illinois for professionals who want to learn about developments in prevention services for families and how to initiate parent education classes and parent support groups. For information contact FRC, 230 North Michigan Avenue, Suite 1625, Chicago, IL 60601, tel: (312) 726-4750.

July 22-28: The *Nursing Child Assessment Satellite Training Program (NCAST)* will hold a training program in Seattle, Washington that includes training in assessment of parent-infant interaction and the home environment, and in intervention approaches. For information contact Georgina Sumner, NCAST, University of Washington, WJ-10, Seattle, WAS 98195, tel: (206) 543-8528.

August, 1989

August 3-6: The *Pre and Perinatal Psychology Association of North America* will sponsor the Fourth International Congress on Pre and Perinatal Psychology in Amherst, Massachusetts. Entitled "Frontiers and Front Lines in Human Development," the Congress will include as speakers Tom Kerny, Michel Odent, Marion Diamond, David Chamberlain, Mary Davenport, Tiffany Field, Michael Trout, Peter Barr, Joan Rafael-Leff, Laurie Sherwin, Candace Fields, James McKenna, Candace Pert, Elizabeth Noble, Lee Salk, and Josephine Chilton-Pearce. For information, write or call Rima Laibow, General Chairperson, 13 Summit Terrace, Dobbs Ferry, NY 10522, tel: (914) 693-8827.

August 3-6: The *National Association for Family Day Care* will hold its fourth national conference in San Mateo, California (near San Francisco). June Sale and Lendon Smith will be featured speakers. For information, write to NAFDC Conference, 815 15th Street, N.W., Suite 928, Washington, D.C. 20005.

August 17-19: The *Peer Support Project* of the *Michigan Society for Autistic Children* will sponsor a national conference in Lansing, Michigan on the concerns of siblings of persons with developmental disabilities. Contact Peer Support Project, 300 N. Washington Square, Suite 2025, Lansing, MI 48933, tel: (517) 487-9260.

August 22-25: The *Infant-Parent Institute* will offer its ninth annual Brief Summer Course in Infant Mental Health in Champaign, Illinois. Michael Trout will be principal instructor, making extensive use of case materials. Contact Mr. Trout at the Infant-Parent Institute, 328 North Neil, Champaign, IL 61820, tel: (217) 352-4060.

September, 1989

September 17-20: The *University Affiliated Cincinnati Center for Developmental Disorders* will hold the first of five annual workshops in Cincinnati on "Nutritional Needs of the Child with a Chronic Illness or Handicap." Contact Shirley Ekvall, Children's Hospital Medical Center, 3300 Elland Avenue, Cincinnati, OH 45229.

September 20-24: The *World Association for Infant Psychiatry and Allied Disciplines (WAIPAD)* will hold the Fourth World Congress on Infant Psychiatry and Allied Disciplines in Lugano, Switzerland on the theme "New Directions in Infancy." For information write to Hiram E. Fitzgerald, Department of Psychology, Psychology Research Building, Michigan State University, East Lansing, MI 48824-1117.

September 21-24: *Parent Care, Inc.* will hold its 1989 annual conference in Lincolnshire, Illinois. For further information, contact Parent Care, Inc., 101-1/2 South Union Street, Alexandria, VA 22314, tel: (703) 836-4678.

Call for Papers

The **National Association for Perinatal Addiction Research and Education (NAPARE)** seeks papers on clinical experience and current research on substance use in pregnancy, treatment of drug users and their children, foster care, parenting, and related issues for presentation at its annual national training forum, to be held September 17-20, 1989 in Miami, Florida. **The deadline for submitting an abstract is June 15, 1989.** For a copy of the submission form, contact NAPARE, 11 E. Hubbard St., Suite 200, Chicago, IL 60611, tel: (312) 329-2512.

Journal of Early Intervention (JEI) is the new title for the former **Journal of the Division for Early Childhood.** JEI publishes manuscripts related to developmental, behavioral, and educational intervention for infants and young children with special needs and their families. Manuscripts reporting applied research, integration of the research literature, policy analyses, and basic research with explicitly stated applied implications are welcomed. This journal is distributed to the nearly 6000 members of the Division for Early Childhood of the Council for Exceptional Children, as well as other professionals and institutions. Inquiries or manuscripts for publication should be sent to Dr. Samuel L. Odom, Editor, JEI, Box 328, Peabody College, Vanderbilt University, Nashville, TN 37203.

National Center for Clinical Infant Programs

Call for posters, symposia, case presentations and videos

Sixth Biennial National Training Institute

"Promises To Keep: Directing Research, Resources and Skilled Personnel to Support Infants, Toddlers and Their Families"

December 1-3, 1989
J.W. Marriott Hotel, Washington, D.C.

Institute Themes

NCCIP's sixth biennial National Training institute recognizes the promises to infants, toddlers and families that are implicit in recent federal legislation, state initiatives, community programs, and intervention approaches. To fulfill these promises requires sustained effort and investment in research, in personnel preparation, in ongoing funding for effective programs, and in staff development.

"Promises To Keep" plenary sessions will examine social policy issues, the interrelationship of language and emotional development in infancy, fathers in their relationships with infants and with service providers, and clinically relevant research with special populations of parents and children. Plenary speakers will include Lisbeth B. Schorr, Stanley Greenspan, Lee K.S. McLean, Barry Prizant, David Yoder, Kyle Pruett, Phil Davis, Dorothy Henderson, James Levine, Joy Osofsky, Alicia Lieberman, Dolores Norton and Byron Egeland.

Submissions from the field are invited for four types of presentations concerning research and practice on behalf of normal, disabled and at-risk infants, toddlers and their families.

Poster presentations

A Friday evening poster session/reception and a Sunday morning poster session/breakfast will provide presenters with opportunities to inform and converse with the more than 1200 anticipated institute participants. Posters may describe research findings, service delivery models, public education initiatives, tools for assessment and evaluation, or approaches to parent and professional training.

Presenters will be provided tables on which to mount displays. Handouts are strongly encouraged. Presenters may arrange for slide or video table-top equipment at their own expense.

Symposia

A total of approximately thirty 1½ hour symposia will be offered at sessions on Friday afternoon, December 1 and at morning and afternoon sessions on Saturday, December 2.

Symposia should include no more than 3 presenters, who should offer different perspectives on an issue concerning theory, research, practice or policy related to infants, toddlers and their families. Presenters may be from different disciplines within a setting, from different programs or institutions, or from different political jurisdictions.

Topics are not restricted but should be ones that can be addressed in some detail in the time allowed. Of particular interest are presentations concerning aspects of collaboration among disciplines; effective approaches to underserved populations; research and practice addressing the infant's relationship with grandparents, siblings, extended family, foster parents and professional caregivers; and training for parents, professionals and paraprofessionals.

Since only a fraction of the institute participants will be able to attend any one symposium, individuals who submit symposium proposals and who wish to reach a wider audience are encouraged as well to submit poster proposals that describe their research or practice. To facilitate the review process, there should be separate submissions.

Case presentations

Case presentations, 1½ hours in length, will be offered on Friday afternoon, December 1 and on the morning and afternoon of Saturday, December 2. Case presentations should focus on work with one infant or toddler and his or her family. While the presenter will want to include some information about the context and philosophy of the approach used, the focus should remain on the process of the individual work. Case presentations may describe any aspect of involvement with a child and family including assessment, the development of an IFSP, clinical intervention, or family support. *A discussant from outside the program must be included in proposals for case presentations.*

Videos for training

On Saturday evening, December 2 and Sunday morning, December 3, 45-minute sessions will illustrate the use of video in pre-service and in-service training for professionals, parents and paraprofessionals. Each session will include up to 20 minutes of video (portions of longer videos are acceptable), with commentary from the presenter about the purpose of the video and the way it is used in training.

Submission deadline and selection process

Abstracts and copies of videos must be received no later than Monday, June 27, 1989.

Submissions will be selected through a review process under the auspices of the NCCIP National Institute Planning Committee.

Persons selected to present will be notified by September 1, 1989.

Institute attendance

Symposium and case presenters are required to register at their expense for the entire training institute. Poster session and video presenters must pay full registration fees if they attend institute activities other than their own poster or video session. All presenters will be responsible for covering their own travel, per diem and material costs.

Proposal format

- Each proposal should include a cover page which includes the following information.

1) Type of submission—poster, symposium, case presentation, video

2) Presenter/liaison—name, title, mailing address and daytime telephone number of one person to whom all institute correspondence can be addressed

3) Names, titles, addresses and business telephone numbers for all presenters involved in a symposium, case presentation or poster presentation.

4) Audiovisual equipment needed for symposia and case presentations. Poster presenters may arrange for table top slide or video equipment at their own expense.

- **Symposium** proposals should include six copies of a double-spaced narrative description of the proposed presentation, no more than 3 pages in length. The narrative should present the issue to be addressed, identify the perspectives that will be included, describe the research or service programs that form the basis for the presenters' expertise, and highlight any areas of controversy. A 100-word description of the symposium that can be used in the institute program should also be included.

- **Case presentation** proposals should include six copies of a double-spaced description of the proposed presentation no more than 3 pages in length. Information should be included about the clinical issues addressed, the setting in which services were offered and the assessment, support or treatment approaches used. The proposal should also identify some of the issues likely to be raised by the discussant. A 100-word description of the presentation for use in the institute program should also be included.

- **Poster presentation** proposals should include six copies of a 250-350 word double-spaced narrative description of the research, service, training, public education, or assessment/evaluation approaches to be presented. A 100-word description of the poster for use in the institute program should also be included.

- **Video** proposals should include a copy of the cassette along with a one-page narrative description of the content of the video, highlighting the research or clinical issues it illustrates and the training audience for whom it is intended.

- **Two stamped envelopes addressed** to the presenter/liaison should be included with each submission. One will be used to acknowledge receipt of the proposal, the second to enclose notification of the Planning Committee's decision.

Selection criteria

1. Relevance to research, practice or public policy concerning normal, disabled and at-risk infants, toddlers and their families
2. Clarity and organization
3. Originality and innovativeness
4. Usefulness to practitioners
5. Adherence to guidelines

Send proposals (including cassettes) to:
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For additional information about the National Training Institute, call Emily Schrag Fenichel at (202) 347-0308.

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Drug Exposed Babies: Research and Clinical Issues

by

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Specialists in drug treatment know well the pervasive destructive effects of drug addiction or drug abuse on an individual's capacities to function in daily life. In recent years, however, the drug abuse problem has developed a new face—the face of a baby. Drug-exposed infants are a large and still growing population requiring treatment in newborn nurseries, neonatal intensive care units, and early intervention programs. The increasing prevalence of drug use or addiction among women of childbearing age is redefining the drug treatment problem, bringing new challenges and complexities to professionals working with infants, children and families. Changes in prevalence are due in large part to increasing use of cocaine with its very high addictive potential. We can no longer view drug abuse or drug addiction as problems of individuals; these are problems with a devastating impact on infants, children and families.

Four facets of babies' exposure to drugs deserve special mention.

JOHN DAVID ARMS

First is the sheer increase in the numbers of babies born in the United States who have been exposed to drugs in utero (U.S. House of Representatives, May, 1988). A recent nationwide hospital survey conducted by the National Association for Perinatal Addiction Research and Education (NAPARE) found that the overall rate of deliveries affected by substance abuse

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overall rate of deliveries affected by substance abuse in 36 hospitals was 11 percent, or some 375,000 newborns affected annually (ADAMHA News, October, 1988), with the variation in rates among hospitals (0.4 percent to 27 percent) related chiefly to the thoroughness of the substance abuse *assessment* used. The problem of substance abuse during pregnancy does not seem to be confined to urban settings, nor is it limited to low income women. A 1989 survey conducted by the Select Committee on Children, Youth and Families (see p. 20) found 15 of 18 hospitals reporting 3 to 4 times as many drug exposed births since 1985.

Second, HIV (human immunodeficiency virus) infection in young children is inextricably linked to drug use in adults. Of all HIV-infected children under 13 years of age in the United States, about 80% have a parent with AIDS or AIDS Related Complex or who is at risk for AIDS. (Falloon, Eddy, Warner and Pizzo, 1989) Little is known about the timing of mother-to-child transmission, and reported transmission rates vary, but evidence suggests that approximately 50 percent of infants born to infected mothers are infected. The most common route of maternal infection is intravenous drug use or sexual contact with an intravenous drug user. (For a detailed discussion of transmission, diagnosis, etiology and medical management issues of HIV infection in children, see Falloon, Eddy, Wiener and Pizzo, 1989)

Third, the explosion in numbers of drug exposed babies and drug using parents is threatening to overwhelm already overtaxed foster care systems. Newborns who test positive for drug exposure are often removed, from the mother's custody before they even go home, but drug use is also destroying families who had been making it together, struggling against the odds, families on the margin for whom involvement in the drug use lifestyle is the last straw. Infants and very young children are entering foster care at a disproportionately high rate. Children under three years old constituted 53 percent of children in placement in San Francisco county in 1986. Data from Alameda County in 1988 indicated that new intakes for children through age 12 included 48 percent in the 0-3 age range. More importantly, the number of medically fragile infants entering foster care is creating a new set of demands upon foster families and social workers. Many of these infants are remaining in hospitals for lack of homes deemed adequate to meet their extensive medical needs.

Finally, drug-exposed babies are being born in times that are difficult for mental health and social services programs. Federal or state fiscal policies have resulted in budget limitations for state agencies, for drug treatment programs, and for programs designed to support families or promote healthy parent-child relationshhips. Programs and staff have been caught between fiscally driven cutbacks and need-based demands for more services. They have also been challenged by the need for new program models to treat infant-parent dyads or families who are feeling the consequences of in utero drug-exposure and/or a drug using environment.

Practitioners who work with drug-exposed infants and their families face issues that are as intellectually, emotionally and ethically difficult as any that have confronted our field and our society. This article

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represents an effort to help practitioners evaluate research information and to think about clinical and treatment issues.

Direct and indirect effects of maternal drug use on the infant

A review paper (Jones & Lopez, 1988) prepared for the National Institute of Health's Expert Panel on Prenatal Care points out that direct and indirect effects of maternal drug use on the fetus and infant must be understood and addressed simultaneously. One must consider the effects of drugs on the fetus consequent to transfer of the drug through the placenta (e.g., fetal infarcts attributable to cocaine.) One must consider the effects attributable to changes in the fetal environment (e.g., the THC in marijuana retards placental development, which reduces blood flow to the fetus). One must consider the effects of abused drugs on the *mother's* central nervous system which place the fetus at risk.

Investigators must reconceptualize the effects of drug exposure on the developing fetus and infant. Direct and indirect effects of maternal drug use must be understood and addressed simultaneously.

Summaries of the direct and indirect fetal risks of maternal drug abuse for eight classes of the most commonly abused psychoactive drugs produced a lengthy list with many effects common to several of the classes of drugs. Because many studies demonstrating or suggesting a relationship between specific drugs and specific fetal risks have research design flaws, inferring causal relationships between specific drugs and specific fetal risks is uncertain business. The question of specific drug effects aside, the research does indicate that it is in behavioral and neurobehavioral domains, rather than growth parameters, that effects of prenatal drug exposure are most consistently documented if adequate developmental assessments are made.

Jones and Lopez' review of the research suggests that investigators must reconceptualize the effects of drug exposure on the developing fetus and infant. For example, infants exposed to drugs in utero are frequently referred to as "addicted infants." This may or may not be the case. Some drugs are addictive. Some are toxic. Some are teratogenic. Both addictive and toxic drugs can cause the newborn to be sick, small for gestational age, low birthweight, and/or premature. The addictive model assumes that the neonate will undergo withdrawal, after which the infant will grow and develop more or less as if addiction had not been part of his or her short life experience. The toxic model assumes that direct injury to the infant may have occurred.

Teratogenicity is more complex. Unless there are identifiable anomalies at birth, the infant can appear to be free of symptoms. On the other hand, the infant may look like a sick, inconsolable baby undergoing drug withdrawal. These symptoms, however, may actually be the result of the effects of drugs on the developing endocrine or central nervous system. (These behavioral and developmental teratogenic effects of drugs are of particular concern to child development and human services practitioners; if thresholds of pain in the infant are modified, or if the capacity for state regulation, attention, interpersonal relationships and human bonds are compromised, the future of that child is at risk). Teratogenic effects can also reside in the genito-urinary and/or cardiovascular system. These effects are

Editors' note

Practitioners who work with drug-exposed infants and their families face issues that are as intellectually, emotionally and technically difficult as any that have confronted our field and our society. The articles in this issue of *Zero to Three* reflect the work of clinicians, researchers and policymakers who are trying to understand this heterogeneous population of children and families and to address their complex needs.

The reader will notice an inevitable tension between authors' attempts to make useful generalizations concerning drug-exposed babies and their families and cautions about stereotyping. Contributors also differ about the most promising service approaches—although all agree that treating substance-abusing parents simply as criminals is a grave disservice to them and their young children. Missing from this issue entirely is a discussion of drug-using parents whose affluence allows them to avoid detection through hospital urine assays and other means, and whose infants' developmental difficulties are unlikely to be attributed to drug exposure.

Clearly, our field and our society have much to learn about supporting the optimal development of drug-exposed infants and their families. As in any work with children and parents, we need to be guided by careful, empathic attention to the unique experience of each infant and parent. This quality of thoughtful attention is, we believe, the hallmark of the articles in this issue.

The editors wish to thank Donna R. Weston and Barbara Ivins for their invaluable contributions to this issue of *Zero to Three*. Dr. Weston and Dr. Ivins organized the December, 1988 NCCIP's Fellows' symposium that inspired this special issue; they also identified clinical and research approaches to be reported and coordinated the bicoastal collaboration that produced the lead article.

The editors welcome letters from readers that reflect their own experiences in research, practice and policy development relating to drug-exposed infants and their families. To the extent possible these will be published in future issues of *Zero to Three*.

influenced by time and dosage of exposure, the systems which are under development at the time of exposure, and genetic vulnerability of individuals. Those drugs that act on metabolic, endocrine and central nervous system functions may not cause the appearance of symptoms until specific developmental stages occur in childhood or adolescence.

The infant is not only at direct risk from the effects of the drug(s) used by his mother in pregnancy but also at indirect risk from the mother's behavior. The *Diagnostic Statistical Manual of Mental Disorders, Third Edition—Revised* (DSM-III-R 1987) defines and examines behaviors caused by each class of psychoactive substance. The types of maternal behaviors associated with drug-induced organic mental disorders (psychological or behavioral abnormalities associated with brain dysfunction and caused by psychoactive substances) can place infants at grave risk. Jones and Lopez (1988) report maternal seizures following large drug doses, sometimes resulting in death; paranoid and suicidal ideation; violent or aggressive behavior, particularly with stimulants such as cocaine or with PCP; the commission of harm to self or others while reacting to delusions; accidents caused by impaired motor coordination; and death from respiratory depression following high doses.

Reading the research

A rapidly growing research literature strongly suggests that drug use during pregnancy is linked to a multitude of problems in pregnancy outcome, infant status, and individual development. As is often the case in a new area of research, reports may conflict in their findings regarding the impact of drug exposure on the fetus, neonate and developing child. Clinicians who provide care for drug-exposed infants and their families would do well to keep in mind three important considerations as they read interpretations of data from experiments, whether these are well controlled laboratory trials or unfortunate natural experiments such as the "crack" experience. These considerations are: 1) limits on the usefulness of animal studies; 2) the validity of self-reported drug use; and 3) failure to take account of many interacting variables affecting this population.

Animal studies can elucidate the mechanisms by which drug exposure damages the fetus (teratogenicity) in humans and can possibly provide early information about the effects of a previously unidentified teratogen. But because of species, strain, and individual differences, generalizing results of animal studies to humans can also involve important errors, false positives and false negatives. Thalidomide testing, for example, showed only occasional teratogenicity among 10 strains of rats, 15 strains of mice, 11 breeds of rabbits, two breeds of dogs, three strains of hamsters, and eight species of primates (Lewis, 1987).

Reliance on self-report to determine drug use can lead to spurious findings. Results of a recent study (Zuckerman, et.al., 1989) indicated that women who had positive urine assays for marijuana and cocaine had infants with impaired fetal growth. Among these women, 16 percent of the marijuana users and 24 percent of the cocaine users denied the use of these drugs and were identified solely on the basis of a urine assay. Had the investigators relied only on self-reported drug use, they would have found no significant differences between the supposedly "drug-using" and "non-drug-using" groups.

The interaction of drug use, health and mental health status, sociological, and ecological variables is seldom examined in perinatal research, but the reality is that the consequences of drug exposure are intensified by an array of maternal health behaviors which tend to be associated with the lifestyle of drug abuse. For example, although drug users tend to have a "drug of choice", they also tend to take the substances they can get, and to mix alcohol, cigarettes, and illicit drugs, rather than rely on any one class or type of drug exclusively. Thus, studies of the effects of cocaine exposure, or studies of heroin exposure most likely are, in reality, studies of polydrug exposure.

The effects of drug exposure on the infant can also be compounded by postnatal factors. For example, drug-exposed infants who experience adequate parenting in an adequate environment may have better developmental status than drug-exposed infants whose experience postnatally is comprised of neglect and other stresses.

Clinical and treatment issues

Lack of *any* treatment is the foremost issue for drug-using or drug-addicted pregnant women. Most such women are receiving neither prenatal care nor drug treatment services. Women who seek help during pregnancy cannot get it, according to the 1989 Select Committee survey; two-thirds of the hospitals queried reported that they had no place to refer substance-abusing pregnant women for treatment.

In their 1980 effort to survey programs concerned with the provision of services to drug-abusing women, Beschner and Thompson identified only 25 programs nationwide serving 547 women. Roughly half were providing psychological and family counseling, and a third provided skills assessment and education counseling. Few programs were making an attempt to serve the children of drug-abusing women. The disparity between services offered and services required was highlighted by Beschner and Thompson's findings that women entering treatment programs are likely to present chronic medical and complicated psychosocial problems demanding special attention, and that the higher levels of personal distress and lower levels of self-esteem found in drug-using women, as compared to male drug abusers, indicate the need for special counseling and support services seldom found in existing drug programs. Eight years later, although some pioneering treatment efforts exist, Jones and Lopez (1988) report that "no preventive intervention programs have been located which are targeted specifically on [drug abusing] women and prenatal care."

The challenge for the field is to design programs that can be preventive in focus and comprehensive in design, involving prenatal care, drug treatment, and infant-parent support.

Practitioners and program planners currently face two formidable tasks: 1) applying whatever treatments are currently available while 2) simultaneously

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assimilating the growing clinical and research data in order to develop more apppropriate new models for service programs and treatment approaches. Clinical issues and treatment considerations that must be addressed in this process include: 1) the danger of stereotyping; 2) focusing the treatment effort; 3) the impact of the work upon helping professionals; and 4) the development of a conceptual framework that assists clinical and research efforts.

The danger of stereotyping

Available information about the impact of specific and polydrug use on physiology, behavior, and development tends to cite commonalities in the characteristics of drug-using mothers and their babies. Mothers are likely to be described as having a history of poor prenatal care, dysfunctional relationships, chaotic lifestyles and poor parenting. Drug-exposed infants tend to be described in terms of irritability, hyper- or hypotonicity, depressed growth parameters, compromised state regulation and possible developmental delays. Emphasizing only commonalities, however, suggests that a homogeneous group of drug-using mothers and drug-exposed babies exists. In fact, the opposite is the case. Drug use includes many patterns that range from occasional casual use of low doses to episodic intake at high doses or the compulsive use associated with drug dependency. The differences between use and addiction and the causes underlying them have different implications for parenting capacity. Moreover, not all babies exposed to drugs in utero will be affected, nor will those who are affected be affected in the same way. Stereotypes can blind us to the unique characteristics that both infants and mothers bring to their relationships despite the impact of drugs. Treatment efforts must recognize, respect and support individual differences while addressing the very real risks that these mothers and infants face.

Focusing the treatment effort

Whether she is treating a single drug-involved dyad in a mixed practice or is working in an environment where drug use is the norm, the clinician must make a series of decisions about the type and focus of treatment. The complexity of drug use virtually guarantees that these decisions will have to be made in the absence of sufficient information.

First come decisions about whom and what to treat. Whatever their specific drug exposure experience, drug-exposed infants are likely to have health problems (low birthweight, complications of prematurity) and to be more difficult and demanding, and less responsive and rewarding, than even "difficult" healthy babies. Drug-exposed babies tend to be compromised in their capacities for state regulation, participation in the subtle give-and-take of interaction, and communication about their states and needs through smiles, frowns, cries and eye contact. These biologically vulnerable infants are born to mothers who face health and emotional problems of their own and who are also compromised in their relational capacities and ability to understand and respond to their infants' needs. Thus these infants experience a double jeopardy: biologic vulnerability due to drug exposure that is exacerbated by inadequate caretaking (Parker, Greer, and Zuckerman, 1988). The multiple needs of infants and mothers produce a strong impetus to treat mother and baby separately. However, the true clinical challenge is to provide interventions to support the mother and protect the infant, while additionally promoting positive mother-infant interaction and the formation of a positive relationship.

Treatment strategies are further complicated by the cumulative occurrence and complex interaction of mothers' health behaviors and psychosocial factors. Depressed mothers and those with "dual diagnosis" require special attention. True addiction calls for even more intense and comprehensive intervention.

Observations from a recent study (Zuckerman, et al., 1989) suggest that depressive symptoms in women and associated health behaviors may be an important link between the social environment and infant outcome. Not surprisingly, the study found that depressive symptoms were more likely to occur among women with a low level of social support and a high number of life stresses. Women with more depressive symptoms were found to be more likely to smoke cigarettes, drink alcohol, and use cocaine—possibly as a form of self-medication, a way of coping with unhappiness and stress. These women also had poor weight gain during pregnancy. Such poor health behaviors in combination are likely to lead to poor outcomes for newborns, and, of course, sick, difficult babies may further stress parents and increase depressive symptoms, which have adverse effects on the developing child.

Efforts to interrupt such a process must consider a woman's emotional and mental health, economic circumstances, and social context. Well-intentioned but unrealistic interventions may simply set women up to fail. If a potentially harmful health behavior serves as a means of coping with depressive symptoms or life stresses or is, as in poor weight gain, itself a symptom of depression, providing information about the risks of poor health behaviors during pregnancy is unlikely by itself to improve women's health and pregnancy outcomes. Interventions that identify women's existing coping strategies, help develop more healthful ones, and focus on reducing stress and depression in the context of a therapeutic relationship may help women master feelings of helplessness and change their behavior. Efforts to reduce alcohol consumption among heavy drinkers during pregnancy that have used this kind of counseling approach have demonstrated beneficial effects to the newborn. An intervention characterized by emotional support and behavioral strategies to help pregnant women reduce cigarette smoking resulted in an increase in birthweight among their newborns (Zuckerman et al, 1989).

The "dual diagnosis" woman has both a drug problem and a psychiatric problem. A pregnant woman who is schizophrenic and is addicted to cocaine, for example, may find that her psychiatric condition is an obstacle to her effective participation in drug treatment. Although she will have difficulty communicating with and relating to others, staff in most drug treatment programs may not be able to identify her difficulties as signs and symptoms of schizophrenia; her mental illness will go untreated, and her drug treatment may also be ill-fated. Women with borderline personalities frequently have difficulties with drugs as well. The Detoxification Program at the District of Columbia General Hospital estimates that 25 percent of patients treated have dual diagnoses.

When drug use is in fact *addiction*, intense and comprehensive intervention is needed. Jessup and others (cited in Jessup, 1983) suggest that pregnancy and motherhood are psychologically loaded issues for chemically addicted women, many of whom feel that motherhood is the only socially acceptable role remaining to them and the only avenue open to achieving feelings of self-worth (Finnegan, 1979; Rosenbaum, 1981). The most difficult psychological task during pregnancy for chemically addicted women, who tend as a group to have poor self-esteem, is the management of guilt and regret about drinking or drug use. If a woman's child is born ill or in withdrawal and the mother attributes the abnormality to her drug use, her guilt may be very great indeed, but it may not be expressed directly. In addition, actions including failure to form an affective bond with the infant, neglect, abuse, and abandonment may each be products of unconscious processes (Fraiberg, 1975). Practitioners must be well trained and caring individuals who can support mother-infant interaction and promote the mother's capacity to become the protector of her infant. Intervention must acknowledge the simultaneous needs for drug treatment and good infant care. It must recognize individual dynamics that may impair the mother-infant relationship (Fraiberg). It must address barriers to formation of a working alliance. (Seligman and Pawl, 1985).

Impact on helping professionals

The increased concentration of drug-exposed infants in neonatal nurseries, early intervention programs and foster homes has created new problems for helping professionals. The prevalence of drug-exposed babies has changed the very nature of many human services jobs, with interventions that were once limited to infrequent, high risk situations becoming the norm,. The already difficult care of medically fragile, ill, or developmentally delayed infants who may start life with extended hospital stays is further complicated by issues of parenting ability, resources in the home, and basic safety. Follow-up is ofen difficult. Protective service referrals and out-of-home placements (often involving frequent moves and a series of primary caregivers for the infant) become routine interventions. Social workers, NICU staff, discharge planners, and early intervention specialists cope with heavy caseloads, spend a disproportionate amount of time searching for and contacting parents, and struggle to establish some sort of working alliance with them. For many practitioners, the change in responsibilities and in their perceived effectiveness of their work bring high stress, decreased job satisfaction and the need for new coping strategies.

Recognition and ongoing discussion of the special difficulties faced by professionals who treat drug-exposed infants and their families are critical to the delivery of quality care. The array of feelings aroused by the work must be acknowledged. Early rescue fantasies can give way to feelings of helplessness and anger. Particularly in work with infants, these feelings are compounded by a sense of urgency related to the awareness that the babies stranded in hospitals or bouncing between foster homes are in developmental periods critical for the development of attachment, affect, self-regulation, and cognition. Professionals may wrestle with their own feelings of attachment to babies who have been entrusted to their care, and find it difficult to maintain feelings of empathy, concern or helpfulness for mothers without becoming judgmental or even, unknowingly, punitive. For professionals accustomed to feeling effective in their work, these feelings can be intolerable. But recognizing them is a critical first step toward forming a working relationship with a family or implementing a treatment plan.

Whatever their emotional state, few professionals have adequate preparation or resources to handle such a large proportion of high risk cases. Service delivery programs must allow for ongoing supervision, consultation, and peer support so that problems, feelings, and particularly troublesome treatment issues can be shared. Caseloads must be monitored by supervisory staff and staff members' concerns about their caseloads respected if feelings of ineffectiveness and burnout are to be prevented. As frontline workers, foster parents also need support. In-service training and staff education on drug effects, drug treatment, infant-parent interaction and high-risk dyads are essential supports for those who are supporting babies and their families.

A conceptual framework to assist clinical and research efforts

"Deficit models" are as dangerous in addressing the needs of drug-exposed infants and their families as they are in thinking about any group of children or adults. A deficit model for drug exposure in utero assumes that the baby has experienced some neurochemical or other fundamental damage to the organism's capacities for self-organizing and self-righting (Washington, 1975). Symptoms of drug exposure such as impaired self-regulatory capacities, hypertonicity, and respiratory difficulties are also observed in full-term, otherwise healthy babies who have not been exposed to drugs. Yet any difficulty of the drug-exposed infant is attributed to the single cause of drug exposure, and the complexities of the impact of drugs on parents and children are deemed beyond understanding and preventive interventions, beyond professional help. The deficit model can be used to rationalize giving up on drug-exposed infants and their mothers.

A "risk model," on the other hand, recognizes that fetal exposure to drugs compromises or jeopardizes developmental processes but that organismic and environmental forces can contribute to positive developmental outcomes. Prospective studies of risk have repeatedly indicated that developmental outcomes are the product of both constitutional make-up and environment, and that a dynamic, transactional model is needed (Sameroff and Chandler, 1975; Werner and Smith, 1982).

The challenge for researchers and practitioners becomes one of learning how better to help drug-exposed infants with compromised capacities reach out to the world, and to support their families in creating a world worth reaching for.

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The Development of Young Children of Substance-Abusing Parents: Insights from Seven Years of Intervention and Research

by

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Addiction is a tragedy that affects the personal lives of substance abusers, their ability to be parents, and their children's development. Drugs and alcohol affect the developing fetus; prenatal drug exposure and parental impairment from chronic drug abuse both affect the developing child. Our research on the developmental sequelae of prenatal drug exposure and the effects of being reared in a substance-abusing family is informed by the patterns, questions and methods of normal child development. But our efforts to reach, assist, and understand substance-abusing families and their young children over the past seven years have been anything but ordinary.

Unique issues in working with substance-abusing families

The foundation of informed and illuminating research about the developmental effects of both prenatal exposure to illicit drugs and postnatal impact of living in a family that abuses substances is the provision of clinical services that address the prevalent survival needs of substance-abusing women and their children. Clinical services are necessary not only on ethical grounds, but are the primary means of maintaining subjects in a research study. Substance-abusing parents are unstable, move frequently, lack telephones, fail to keep appointments, and drop out of sight when abusing illicit drugs. Friends and often family collude with the substance-abusing person's flight from representatives of authority structures such as universities, medical and legal systems. We have found, therefore, that it is very important not only to provide clinical services but to provide them through an intervenor who is able to establish an ongoing, stable, nurturing, and non-threatening relationship with the subject.

Substance abuse undermines normal patterns of interaction and alters conventional priorities (Howard, in press). The families we have worked with, who are poor and are chronic polysubstance abusers, have multiple legal, social, and medical problems. They often come from a history of impoverishment, abuse, and intergenerational chemical dependence. One mother, for example, told us how her mother taught her to shoplift and then to sell the stolen goods on the street. This mother was introduced to heroin by her own father. (In fact, a significant number of parents experienced their first exposure to drugs and alcohol through their own parents' encouragement.) Another mother told us that when she was upset as a child her mother would mix her a drink and say, "Drink this; it will make you feel better." A third mother stated that her own father "shot me up with heroin when I threatened to call the cops on him."

NANCY P. ALEXANDER

Clinical services that address the survival needs of substance-abusing women and their children must form the foundation for research about the developmental effects of prenatal drug exposure and the impact of living in a family that abuses substances.

Parents who are addicted to drugs have a primary commitment to chemicals, not to their children. Disruption and chaos in the household often result in the neglect or disregard of the child's needs. For example, a three-month-old baby in one of our research projects was found underneath a bed by a neighbor. The baby's parents and friends were high and consequently not merely inattentive to the baby's needs but completely unaware of the baby's presence. Another mother explained her inability to keep medical appointments for her child because she was out "chasing the bag"—that is, looking for drugs. Yet another mother explained her pregnancy by stating that "I need this baby to help slow me down, to keep me off the streets".

Chronic drug use can impair and distort a parent's thoughts and perceptions. Chronic use of mind-altering

History of Our Work with Substance Abusing Families

The UCLA Department of Pediatric's introduction to substance abusing families grew out of the UCLA Suspected Child Abuse and Neglect (SCAN) Team. Newborns exhibiting withdrawal symptoms from prenatal exposure to drugs were required by California law to be reported to the Child Protective Agency as possible child abuse cases. The SCAN Team enlisted our expertise in child development to identify atypical behaviors that might be indicative of drug exposure and withdrawal, and to assess the impact of the parental addiction on family functioning. A protocol was developed to identify severity of dysfunction in both the infant and the family in order that recommendations could be made to the courts about the medical, ecnironmental, and developmental needs of these children.

From this initial participation in SCAN, beginning in 1981 we developed clinical service projects, an interdisciplinary training project, interagency training projects, and a research study of the developmental effects of prenatal exposure to illicit drugs. These projects had a different focus from traditional programs that target substance abuse. Our emphasis was on the processes of development in the children, the effect of the family environment on the children, and the effect of wider social systems on the children's development rather than a medical model focused on the addiction itself.

The clinical services projects included a three year early intervention program, PROTECT, funded by the Department of Education, Handicapped Children's Early Education Program (HCEEP Grant 024AH50027) that subsequently spawned a statewide interdisciplinary and interagency Outreach Training Grant (HCEEP Grant HO24E80008). Since by this time we were familiar with the nature of substance abuse we made the goals of the intervention purposefully basic and realistic: 1) ongoing health care for identified infants and siblings, 2) developmental assessments and appropriate community referrals for the identified infant and siblings, 3) education to the biological parents, foster parents, and extended family about fetal and infant development and the special needs of drug exposed infants, as well as basic information about child nutrition and safety, 4) counseling for crises and management of daily problems for the biological parents, foster parents, and extended family, and 5) coordination and collaboration among all agencies involved with the identified family.

The multiple needs of the substance-abusing families necessitated both interdisciplinary and interagency cooperation. In order to facilitate the goals of intervention, three professionals were assigned to each family: a social worker, pediatrician, and public health nurse. During a 12 month period these professionals worked with an average of 5 agencies per family and contacted families an average of 52 times. This need for interdisciplinary and interagency collaboration alerted us to the need for specific training, for a wide range of professionals, focused on the issues related to substance abuse.

A project for interdisciplinary training in the area of child abuse, including substance abuse, was implemented for students at UCLA in the graduate departments of psychology and education, and professional schools of medicine, dentistry, public health, law, social work, and nursing in order to prepare these new professionals to respond to these issues as they enter their chosen fields (Child Abuse and Neglect Interdisciplinary Training Grant, Department of Health and Human Services 90-CA-1343). At the same time, training for interagency cooperation between case workers in the Department of Children's Services and nurses in the Los Angeles County Health Department (Training, Education, and Management Skills: Meeting the Needs of Infants Prenatally Exposed to Drugs, TEAMS) was made possible through funding from the Department of Health and Human Services (90-CA-1194).

The research findings from the early intervention project provided the preliminary data for a research grant from the National Institute on Drug Abuse (NIDA Grant RO1DA4139) to study developmental patterns in children prenatally exposed to phencyclidine (PCP) as a primary drug of abuse in the mother's substance-abusing history.

drugs can interfere with memory, attention, and perception. Mothers in our studies have had difficulty remembering their own children's birthdates.

Safety is an issue for family members, for professional staff who make home visits, and most of all for the children of substance-abusing families. Drive-by shootings and violence where drugs are used and sold are daily occurrences in their neighborhoods. Further, children are often in danger because their addicted parents do not function as protectors and advocates. Infancy professionals who have been trained to acknowledge and respect that parents have a primary leadership role in their children's lives must learn to understand that the substance-abusing parent is often unable to assume this primary protective role. The first goal of professionals, therefore, is to keep the child visible in the community in order to monitor the child's safety in a dangerous drug culture.

Unique qualities in the clinical and research staff

Because turnover in staffing interferes with the formation of nurturing, non-threatening relationships with substance-abusing families, continuity in the clinical and research staff becomes essential to success. Just as several characteristics of the drug culture and substance-abusing families are unique, the demanding nature of the needs and problems in families requires a staff of clinical and research professionals who themselves possess specific and unique qualities. Dedicated, stable, and focused professionals who have personal maturity and inner strength, who can be realistic and creative in the face of overwhelming social tragedy, and who have a personal humility that motivates them to organize their relationships to subjects and colleagues from a stance of respect, help reduce attrition in both the subject families and the professional team. Some members of our staff have seen the destructive impact of the drug culture upon family members or friends; others have gone to great lengths to become fluent in the language of street, gang, and drug culture in order to better understand families' descriptions of their life experience. The staff are united in common goals and take problem solving in stride. As one community staff member asked, "How would we know we were alive if there were no problems?"

In our projects, staff turnover has been negligible and our research subject attrition rate minimal. In their relationship with stable intervenors, the subjects experience the rudiments of trust sufficiently to sometimes maintain contact with their intervenors when they are in difficulty. When the intervenor-subject relationship does not result in maintained contact, the intervenor's own knowledge of the community and the community's trust of the intervenor enables her to locate the subjects who have gone into hiding.

Unique problems in research on children of substance-abusing families

Locating subjects is only the first step in collecting data at reasonably consistent times. It is often necessary for the intervenor not only to provide transportation, but also methodically to structure the addict's activities in order to get the subject to the laboratory for assessment. The intervenors in our study not only arrange to accompany and transport the subjects to the laboratory, they often must arrive at the subject's home up to 90 minutes before departure in order to wake mothers, and organize their own preparations and their child's dressing and feeding. In their cars, our intervenors keep diapers, formula, children's clothing, women's clothing, combs, shoes, and personal toiletries to use as needed to ensure arrival at the lab at the appointment time.

These extraordinary efforts are not limited however, to laboratory visits. Observations in the home are equally vulnerable to failure. Subjects who are addicted forget, aren't awake and ready, and leave. If they have failed to tell their network of other drug abusers and sellers about the appointment, they are preoccupied with activities of the addiction, and observation is impossible. When home observations are made for research purposes, the intervenors must also act to ensure the subject's readiness. In substance-abusing families advance preparation is necessary for the collection of data and is critical to the safety of the research staff. It is essential that drug dealers and abusers not be surprised or interrupted by people outside of the drug culture.

The accomplishment of both home and laboratory assessments is governed by a knowledge of families' daily lives. Our subjects are both drug-abusing and poor. Assessments cannot be done on the first or fifteenth of the month when AFDC or welfare checks are received. Cashing and protecting the check from theft (and often from other family members) and spending the money are the priority on these days. Assessments are also not scheduled on Fridays and Mondays because of the anticipation of, preparation for, and recovery from weekend activities. The window of time for home observations is late morning to early afternoon. It is too dangerous for the research staff in the late afternoon and evening because of darkness and increased gang activity after school dismissal.

> *When home observations are made for research purposes, advance preparation is critical to the safety of staff. It is essential that drug dealers and abusers not be surprised or interrupted by people outside of the drug culture.*

Members of the clinical and research staff do not take unnecessary risks in the community by carrying purses, wearing jewelry that looks valuable, dressing in a manner that would be construed as sexually provocative, stopping at service stations, or using public telephones. At the same time they are careful to greet each person encountered in order to diffuse antagonism to those considered to be outsiders because they do not reside in that immediate neighborhood. Even with these precautions, some neighborhoods are still too dangerous for any outside person to enter. In our current research project we have had to drop six families who wanted to remain in the study because incidents associated with drug activity, including guns, shootings, mental disorders, and known gang membership put our staff in personal danger. These difficulties notwithstanding, the knowledge gained from home observations, exposure to the drug culture, conditions of inner city living, and an awareness of the character of daily life events experienced by the children and their families is essential to generating meaningful research hypotheses about developmental process in this population, and to understandable interpretation of the complex findings.

Even when appointments are kept, the quality of disorganization found in the subjects' daily lives is also evident in the laboratory. Research assistants generally need to focus on organizing the mother as much as or more than organizing the child. It is not uncommon for substance-abusing mothers to have difficulty remembering simple instructions or to exhibit difficulties with attention and perception. For example, in a structured laboratory teaching task that required the parent to teach her child how to do a puzzle designed for three-year-olds, the parent struggled without success to orient a triangle so that it would fit into its appropriate spot. The mother then turned to the experimenter and said, "You need to get a file to fix this piece so it will go in." Parents often seek the researchers' attention for themselves or fail to attend, soothe or help their children feel comfortable in the assessment situations. Some mothers who have recently taken drugs fall asleep during the laboratory assessments.

Current findings from our ongoing research

Our current research is designed to extend our understanding of the developmental sequelae of prenatal drug exposure and the effects of being reared in a substance-abusing family. We wanted to discover where normal processes of development had been altered and which developmental processes seemed resilient to the impact of a dysfunctional prenatal and postnatal enviroment. In determining issues for assessment we were guided by two principles.

- First, the effects of prenatal drug exposure would be found in a continuum that ranges from mortality, to anatomical dysmorphology, to more subtle behavioral effects; severity of effect and rate of occurrence in the population would be inversely correlated (1988, September, Prenatal abuse of licit and illicit drugs. Proceedings from the conference of the New York Academy of Sciences). Our observations and knowledge of normal child development taught us that developmental and intelligence tests alone would be inadequate in demonstrating the subtle deficits that would be most common in these children.

Drug-exposed toddlers score within the low average range on structured developmental tests, but they show striking deficits in free play situations that require self organization, self initiation and follow-through.

- Secondly, we recognized that the alternative postnatal rearing environments in which prenatally drug exposed children are placed would mitigate or exacerbate the adverse effects of in utero durg exposure. We understood that haphazard placements by the courts, which resulted in some children being reared in foster homes, some with extended family, and other with their biological mothers, presented a natural experiment for disentangling the effects of prenatal and postnatal environment (Rodning, Beckwith, & Howard, in press).

In our first empirical study we compared 18 prenatally drug exposed 18-month-old toddlers to a sample of high risk preterm toddlers (Beckwith, 1988) who were of earlier age and lighter weight than the drug exposed children, of similar low socio-economic status, ethnicity, and single parent households. We looked at the children's intellectual functioning, quality of play, and security of attachment to the parent or parent figure. High risk preterm children were specifically selected as a comparison group since previous studies have implicated poor prenatal care and difficult perinatal events as the source of negative developmental outcomes from prenatally drug-exposed children (Chasnoff, Schnoll, Burns, & Burns, 1984; Lifschitz, Wilson, Smith, & Desmond, 1985).

The drug-exposed toddlers had significantly lower developmental scores, but were still within the low average range. Because standardized developmental assessments imposed an external structure in which an examiner directed the tasks for the child, the children appeared more competent than we clinically judged them to be. Our clinical observations led us to include within the research assessments an unstructured free play situation that required self organization, self initiation, and follow-through without the assistance of the examiner to guide the task. In that context, the drug-exposed children showed striking deficits. The drug-exposed children had significantly less representational play than the high risk preterm children. Play for the majority of drug-exposed children was characterized by scattering, batting, and picking up and putting down the toys rather than sustained combining of toys, fantasy play, or curious exploration. Representational play events, such as combing hair, stirring a pot, and sitting a doll at a table, were significantly less frequent and less varied in the drug exposed group than the comparison group.

When we looked at the Strange Situation paradigm (Ainsworth, Blehar, Waters, & Wall, 1978), we found a similar pattern of average scores yet very deviant behaviors. The drug-exposed children did not have a significantly higher percentage of insecure attachments than either the preterm sample or that expected in a poverty group. However, the drug-exposed children did not show the strong feelings of pleasure, anger, and distress in relation to novel toys and the caregiver's departure and return that the attachment assessment was designed to elicit. Moreover, the majority of drug-exposed children had insecure attachments characterized by disorganization rather than organized patterns of avoidance or ambivalence. The antecedents of the disorganized classification need to be carefully understood both in the parent-infant interaction and in possible biological factors within the infant.

In comparing securely and insecurely attached children within the drug-exposed group, we found that the insecurely attached children had significantly fewer play events and poorer quality of play than the securely attached children. Even though the securely attached drug-exposed children had more play events than the insecurely attached, both groups were still more sparse and disorganized than the preterm children. Since a link between representational play and language acquisition has been demonstrated in other studies (Bretherton, 1981, Largo and Howard, 1979), we also anticipate problems in language development for the drug-exposed children at later ages.

The data from that initial study, and the preliminary findings from our present research project showed that prenatal drug exposure increased the initial risk evident at birth by extending the organic, physiological effects: 1) into emotional development in affect regulation; 2) into social development in the organization of relationships; 3) and into cognitive development in the representational and symbolic aspects of children's play. The rearing environment, through fostering secure attachment, mitigated the impact of prenatal drug exposure on development to some degree, but did not eliminate the effects entirely.

Clinical and research implications

Children of substance-abusing parents are living in unstable, often dangerous environments, cared for inconsistently by parents impaired by chronic drug abuse. Postnatal environmental factors and the possibility of biological impairments pose grave risks to their healthy development. While resiliency and change are always possible for the child and for the adult, resiliency cannot be taken for granted.

Developmental effects of the multiple adversities that children prenatally exposed to drugs and growing up in substance-abusing families experience daily will have an increasing impact on the educational, medical, social welfare, and justice systems in our society. This burden will only increase as the numbers of children in these circumstances increases. Clinicians and researchers now face the challenge of identifying the services that will prevent and remediate this social tragedy. Communities that are only now organizing their systems of law enforcement and drug treatment to deal with addiction in adults must turn their concentrated attention and expertise to these vulnerable children as well.

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Serving Drug-involved Families with HIV Infection in the Community: A Case Report

by

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Imagine being dependent on drugs, having limited resources, supports and coping skills and learning that you, your child, and probably your partner are HIV-infected. Imagine having a debilitating, terminal illness laden with stigma. Imagine caring for your family alone when you are too sick to get out of bed. Imagine facing your impending death, the death of your child, and the need to plan for the future of your well children. Try to imagine the unimaginable, and it wiill not come close to the experiences of the families the staff of Project WIN has served over the past three years. This article describes the experiences of one such family.[1]

Jill is 27 years old, black and a single parent of two boys, aged 6 and 5, and twin girls aged 2 years. She and the children live in a third floor, two bedroom walk-up in a neighborhood where drugs are dealt openly and people are victims of violence every day. Jill used marijuana, but never intravenous drugs. Her partner, Rick, the father of her children, has a long history of intravenous drug use. When the twins were born, Jill learned that she and the twins were diagnosed as HIV-positive. At 15 months the twins were tested again to determine whether they continued to carry AIDS antibodies. This test, and a subsequent test done when they were two years old, were negative, confirming that the twins are not HIV infected.

Jill first developed symptoms of pneumocystis carinii pneumonia (PCP) when the twins were 10 months old. She was hospitalized for treatment at a major medical center in Boston. A hospital social worker, who sat on the WIN Transagency Board, referred Jill to WIN for assistance in coordinating community services for her family. In the past fifteen months, Jill has been hospitalized nine times, for periods of up to three weeks. She has had recurrent bouts of PCP, oral thrush, meningitis, monilia, dangerously low potassium levels, nausea and dehydration. For five hours a day, five days a week, for the past seven months, Jill has received medications via infusion therapy. Severe candida in her throat makes swallowing impossible, and she has a gastric tube inserted for liquid nutrition. Jill weighs 85 pounds, she is frequently weak from coughing and profuse vomiting, and she is often too dizzy to stand. She is on a range of daily medications to control her symptoms, including AZT, amphotericin, iv antibiotics, and pentamidine.

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[1] As in all case reports that appear in *Zero to Three*, certain identifying information has been altered to preserve confidentiality.

PROJECT WIN

Project WIN, a division of the South Shore Mental Health Center, is a Boston-based model demonstration project funded by the Handicapped Children's Early Education Programs and the Boston Foundation. The Project builds on the experiences of a previous model demonstration project, PACT (Parents and Children Together), which was the first project to employ the transagency service delivery model with multiproblem, intravenous drug dependent, alcoholic or incarcerated women and their children.

WIN's services are targeted at preschool-aged children from families in which the parent has a history of intravenous drug use, the children are at risk developmentally and the family members are at risk for or diagnosed with HIV infection. Direct services are aimed at supporting the parents' recovery from addiction, identifying and providing home-based early intervention for the children's developmental needs, and helping the family find and use the services they need. The ultimate goal of WIN is to enable families with AIDS to stay together in their homes and to reduce unnecessary hospitalization of HIV-infected children and adults.

The WIN team consists of a director, coordinator, three case managers with backgrounds in social work, education and counseling, and consulting family, speech and physical therapists. Staff members from these different disciplines function as a transdisciplinary team, assessing children and planning family-focused interventions together. Each case manager works with no more than 10 families. Small caseloads allow the case managers to provide families with the intensive attention they often require. The transdisciplinary team members work with the children and their families in their homes, motels or shelters. The family is defined as the client.

Case management efforts coordinate the implementation of community services to ensure that families receive all necessary supports in a cohesive and manageable service plan. The service providers involved with the family design the work from one service plan that addresses all the family's service needs. Through frequent discussions and regularly scheduled case conferences, service providers review the service plan and interventions, define roles and responsibilities and the timing of service delivery.

All activities of the project are guided by a transagency board composed of representatives from 31 different community agencies who meet monthly to plan and monitor services to families. Health, education, addiction treatment, and child and social service agencies are represented on the board. Board members refer children and families for WIN services, recommend interventions, arrive at a consensus regarding a community service plan that is appropriate and manageable, review and evaluate service plans and monitor delivery of services.

Delivery of services is governed by the philosophy and principles of the transdisciplinary and transagency models. The transdisciplinary (TD) model requires team members to plan for the child and family in a comprehensive manner. Family interventions are carried out by one team member, called the primary service provider. Transagency service delivery reflects an expansion of the rationale and principles of the transdisciplinary model to community services. Both models have proven effective with multiproblem families requiring the services of many agencies and providers.

The transdisciplinary model reduces service duplication, overlap and fragmentation for the child and family within a single program by facilitating team communication and palnning. Similarly, the transagency model reduces duplication of services among multiple community agencies. The model bridges service gaps for the child, the family and the service providers within the community by facilitating communication, establishing a process for defining providers' roles and responsibilities, and by assigning one provider to act as the family's case manager.

Jill is determined to live. She says that she lives for her children, and her love for them is what keeps her going. In spite of her illnesses and frequent hospitalizations, her family functions, her children are well cared for, generally healthy and appear to be happy. Jill also cares for others in need. She is the central, driving force in a large extended family. Connection to Jill keeps everyone else connected to each other. Despite her illness, her dependence on service providers and systems that have often failed her, she has no bitterness, and demands no favors. In fact, Jill is often reluctant to ask for help and to talk about her feelings and her sadness about dying. She usually withdraws into herself when she is troubled. She has survived longer than anyone expected.

Although she is hesitant to ask for help, Jill talks clearly about her needs for services. She also follows through on securing and using services to an amazing degree, considering the limitions imposed by her deteriorating health and physical incapacity. She keeps health clinic appointments for the children, gets them off to school or day care each day, clean, fed, and appropriatley dressed. She makes necessary calls, keeps appointments, attends case conferences, completes applications and provides necessary documents, and talks with the providers necessary to secure services for herself and her children.

Jill's sons are robust, healthy and doing well. They have had the usual share of childhood illnesses. All four children have had the chicken pox and measles. The twins have had many health problems including recurrent ear infections, rashes and enduring chest colds. They have also shown developmental delays. In assessments performed by the WIN team the twins were found to have delays in social and speech and language areas. The case manager referred the children to the early intervention program whose director sits on the transagency board (see box). He also arranged for the children to have speech therapy at home while they waited for the early intervention slots to open.

In spite of their mother's illness, all four children appear to be relatively stable, and at ease with family members and strangers. The two older boys attend school regularly and are cooperative participants in their after school programs. None of the teachers or school administrators have voiced concerns over the boys' adjustment or behaviors.

Except for their delayed language, the twins appear to be typical toddlers with very distinct personalities. The older twin, Ronnie, is larger, more active and more aggressive than her sister, Bonnie. Bonnie is quiet and reserved, and enjoys more subdued activities such as cuddling and drawing. The case manager and consulting developmental specialists have felt that the girls' behaviors and personalities are well within the normal scope of toddler behavior. The children appear secure and competent. They appear comfortable with Jill and Rick, their parents, comfortable entering new or strange situations. Like the older boys, the twins have adjusted well to day care and to their early intervention program.

When the hospital social worker referred Jill, she was sharing her two-bedroom apartment with Rick's sister, Sally, and Sally's four children, aged 5, 4, 2 and 6 weeks. Sally had been evicted from her apartment and was waiting for placement in the public housing complex. Sally cared for all eight children while Jill was hospitalized. Sally did not know that Jill had AIDS or that the twins were HIV-positive, and Jill wanted to be sure that this was kept secret from her, fearing that if she knew, she would move out and there would be no one to help her.

Jill appeared to be near death when she first became a client of WIN. As a single parent, it was imperative that she write a will estabishing custody of the children. The case manager and hospital social worker agreed to contact an AIDS advocate to help Jill find a lawyer to take care of this. Three months later and two hospitalizations later, Jill had a will giving her mother power of attorney and custody of the children. Jill would not consider giving Rick custody because he was not dependable, and she was not convinced that he could give up heroin. (Rick has refused to be tested for HIV.) Although Jill has expressed reservations about having her mother care for the four children because she already cares for a grandchild with severe special needs, she feels that she has no other choice. Her mother has agreed to take the children. During Jill's many hospitalizations she has helped Jill with the children whenever able. The children are comfortable with their grandmother and talk fondly about her.

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Jill's highest priority for services was finding day care for the twins so that she could get more rest. Both she and the hospital staff ststed that if she could get enough rest, she would stay healthier. Achieving quiet at home was difficult because Jill's apartment was crowded and noisy. Although Jill's boys were in full-time day care with transportation provided, the twins were at home. Jill had no day care for the twins, and no way to transport them. Because they were babies and because she wanted to have as much time with them as she could, she wanted them to be at home. She thought a homemaker coming to the house would help her with the twins and the housework.

Helping Jill find a homemaker proved more difficult than first imagined. It took months for the case manager to secure a homemaker to make daily visits. The plan was for the homemaker to provide multiple services in order to reduce the number of professionals involved with the family. With instruction and supervision from the WIN case manager, she would engage the twins in developmentally appropriate and stimulating activities as well as perform housekeeping tasks for the family.

After one training session and visit, the homemaker did not return. A week later, calling to find out how the homemaker was getting along with the family, the case manager learned that the homemaker's husband did not want her going into Jill's neighorhood or working with someone with AIDS. It took more than a month to find another homemaker. There have been at least four different homemakers who have come to Jill's house in the past year. Sometimes weeks elapse between placements.

Jill is served by a number of different social service agencies and providers. The WIN case manager, along with a visiting nurse, coordinates services for Jill. The visiting nurse coordinates the nurses who come almost daily to help Jill with the infusion therapy and to check on her health. The WIN case manager monitors the children's development and arranges for concrete support, counseling, advocacy and case management services for Jill. When Jill is hospitalized, she works with a hospital social worker and the AIDS coordinator. In the past 15 months, Jill has had at least five different case workers from the Department of Social Services assigned to help her find day care for the children. One refused to work with Jill after being assigned because she did not want to work with "people with those problems". Jill also has an AIDS advocate, who helped her write her will.

During the first three months that Jill was involved with WIN, she was hospitalized four times, and the twins were hospitalized and treated for ear infections once. Sally and her children were still living with Jill, and Sally was taking care of all the children each time Jill was in the hospital. After living with Jill for nine months, Sally was hospitalized with an undisclosed illness. Jill was left caring for all eight children. Shortly after Sally was discharged from the hospital, she and Jill argued and Sally moved with her children to a shelter. Sally's mother then spread the word in the neighborhood that Jill had AIDS.

Rick, who had visited Jill and the children intermittently, started spending more time there. Although he was high much of the time, he helped Jill with the children. In the summer of 1988 he moved in with the family. Jill was frustrated with his continued drug use, but she felt that she had to put up with it, because the children needed their father.

In September, 1988, Jill was again in the hospital. The older children were ready to enter school, one in first grade and one in half day kindergarten. They were assigned to two different schools at opposite ends of the city. Rick and Jill contacted the school administration and were able to change the assignment so that both children could go to the same school in their neighborhood.

However, since they were in a neighborhood school, they were not eligible for transportation. There was no way that Jill could walk them to school each day, and she would not let them walk to school alone. It took a month of telephone calls, applications, and negotiation for the WIN case manager to arrange transportation.

While they were waiting for the transportation service to begin, the children were accompanied to and from school by Rick, or by Jill's brother. Neither was too dependable because they were both drug users. When no one else was available, the case manager walked the kindergartener home mid-day.

With Jill hospitalized and her health precarious even when she was at home, the older children needed after-school care. The case manager located an after-school program in Jill's neighborhood that could take both boys. He secured slots and helped Jill complete the application forms, which he then delivered to the program. Enrolling the boys required the WIN case manager to make 20 telephone calls, 6 meetings and 4 trips between the hospital and the after-school programs in just one week. He was able to arrange to have the boys' school transportation deliver them to the program, but there was no transportation home. Unable to find volunteers, the case manager obtained money from the AIDS support group and arranged to pay an after-school staff member to accompany the children home each day.

In October, 1988, Rick entered a 21 day inpatient drug treatment facility. Home from the hospital, Jill arranged to visit him, but her visit was traumatic. Rick's counselor turned the visit into an interview about Rick's future. During the interview the counselor asked Rick what he planned to do and where he planned to live after Jill died. He never addressed Jill directly, but spoke about her in her presence as if she were already dead. Jill reponded to the counselor's insensitivity to her feelings by quietly withdrawing and not talking about it.

In November, a family day care placement with transportation finally came through for the twins. This proved to be near-disaster. After they had been in this day care home one month, the agency worker called Jill, again in the hospital, to tell her that the twins had been "bumped" because other children needed to be placed in that home. What she did not tell Jill was that the day care provider deduced that Jill had AIDS and refused to continue caring for the twins. The provider also told other day care providers about her suspicions, and they in turn refused to take the children into their homes.

Jill was shocked, upset and demoralized when she learned why the twins lost day care services. She said that she didn't understand why her problems had to affect her children. The case manager confirmed the civil rights violations that had taken place and explained to Jill the courses of action that she could pursue. He talked with the day care director about the legal implications of this violation of Jill's confidentiality, stressing the necessity for the day care agency to find another placement.

At a meeting arranged by the case manager, the day care director explained to Jill how the information leaked out. She told Jill that one positive outcome of the experience was that the staff and day care providers were going to receive training about AIDS. She promised Jill that the twins would be in a new day care placement the next day. Since that time, the children have remained in this day care home.

During the summer the morning homemaker had stopped coming to Jill's. The placement agency was not even aware that there had been a lapse in homemaker service. After more than a month of calls and prompting, another homemaker was assigned. Homemaker number three quit after coming to the house once. The placement agency told the case manager that it was difficult to find homemakers willing to help people with AIDS. Rick, home from the detox facility, berated the case manager for not doing enough to help Jill.

In the hospital once again, Jill told the case manager for the first time that she was afraid to die, and she felt angry that she won't see her kids grow up. This was a significant statement in light of her continual reluctance to talk about her feelings about her illness and to seek comfort.

In January, after being hospitalized over Christmas, Jill returned home. The case manager visited Jill at home and found Rick high on heroin, the twins home from day care with conjunctivitis, and Jill's apartment flooded by her washing machine, which had broken down. Jill asked the case manager to help her have the machine repaired. After several telephone calls he found a repair service that would come to Jill's neighborhood; however, cash payment was required to pay for the repair. The case manager secured the payment from WIN's emergency fund and arranged to have the washer repaired. He delivered an electric heater provided by WIN's "Secret Santa," which Jill had requested because she was always cold in the apartment, and some needed winter clothing for the children. He also took to the day care agency the pediatrician's note that the twins were being treated for the infection so that they could return to day care.

In January, Jill's childhood friend, Rose, whom she referred to as her sister, moved into the apartment with her infant. Jill felt a strong sense of responsibility to help Rose straighten out her life, because Rose's mother had cared for her when she was a teenager and had left home. Jill encouraged Rose, who was homeless, to become involved with WIN so that she could get services and find housing.

A crack and heroin user, Rose assured Jill that she would call WIN and that she was going to change her life. However, after less than a week of staying with Jill, Rose resumed drug use. She left the baby with Jill for up to 10 hours at a time, sometimes overnight. When she came home it was often with men. Their noise would awaken Jill. Jill was feeling too weak to put up with this and was becoming upset with Rose.

Rose talked about finding housing and being committed to working with WIN, especially because she said that if she were working with a WIN case manager, her D.S.S. case worker might "get off her back". Despite her stated intentions, she missed the first five scheduled appointments with the case manager. At the sixth and seventh scheduled meetings (which Rose kept), the case manager brought her housing applications, condoms, bleach, and safe sex pamphlets. Rose did not follow through on applying for housing and missed the subsequent appointment. She then "disappeared" for a month. At first the baby stayed with Jill and other relatives. However, when Rose made no contact with Jill or the baby, her D.S.S. worker eventually placed the baby with Rose's mother in a foster care arrangment.

As of this writing, Jill is hospitalized again. Rose is also in the hospital, probably with PCP, and her baby is still with her mother. The twins have started an early intervention program two mornings per week and continue in day care the rest of the time. The older boys are healthy, attending school and the after-school program regularly. Rick is living with the family. He probably is using heroin again.

Implications for service delivery

Jill's situation demonstrates the extraordinary amount of time and effort required to coordinate services to families with HIV infection. Telephoning agencies, arranging visits, dealing with workers at agencies unfamiliar and fearful of AIDS, and coordinating services among providers who are often overtaxed, have too many other cases to handle, or who are bound by the rigidity of their bureaucratic agency structures requires persistence, endurance and creativity.

In fifteen months, the case manager had 43 home or hospital visits with Jill, 57 telephone contacts with her, more than 170 contacts with other service providers, and convened 11 case conferences. More than 175 hours have been spent in coordinating services with other agencies.

The WIN case manager has been able to spend the number of hours required because he carries a caseload of no more than ten families. However, no one agency or service provider could possibly organize and provide all the services these multiproblem and multiagency families need. He has been able to coordinate community and hospital services because he works with other professionals who function as a transagency team. Service providers work together to define roles and responsibilities and to establish the timing of interventions.

Jill has been an extraordinarily committed and motivated client. Although she does not have a history of intravenous drug addiction, her partner is an active drug user, and her lifestyle and neighborhood certainly have been affected by drug addiction. Contrast the ability to engage Jill with the failure to engage Rose, who was using drugs. When people are still using drugs, they are not free to expend energy to accomplish other goals. Drug use is a central force in their lives, displacing other goals, obligations and dreams. Continued drug use correlates with a high failure rate for appointments, limited follow-through on planned interventions, and frequent interactional difficulties, including fights with partners and flight from service providers. For this reason, drug treatment is a non-negotiable goal written into every service plan, and talking about the recovery process is an ongoing part of the work.

When families are coping with HIV infection, their needs and existences are further complicated. Those who are part of the drug culture are already isolated and stigmatized. Infected adults and their children experience additional stigma. Frequently they are

continued on page 17, following inserts

NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS

REGISTER NOW

Sixth Biennial National Training Institute

"Promises To Keep: Directing Research, Resources and Skilled Personnel To Support Infants, Toddlers and Their Families"

December 1-3, 1989

J.W. Marriott Hotel, Washington, D.C.

The sixth biennial National Training Institute of the National Center for Clinical Infant Programs reflects the substantial promises to this country's infants, toddlers and their families implicit in recent federal legislation, state initiatives, community programs, intervention approaches, and policy statements. To fulfill these promises requires sustained effort and investment in research, in ongoing funding for effective programs, in the development of new service models, and in the training and support of personnel.

NCCIP's National Training Institute will bring together the perspectives of those most concerned with strengthening infants, toddlers and their families—parents, professionals from many disciplines, researchers, and policymakers. Plenary sessions, pre-institute seminars, invited special interest sessions, symposia, case presentations, poster sessions and video presentations will reflect current knowledge and practice concerning both normative development and environments and the circumstances of infants and families at risk. Invited presentations and presentations selected from a nationwide call for proposals have been planned to offer training institute participants opportunities to stretch their understanding beyond their own discipline or work experience and to share their own insights with colleagues from all parts of the country and abroad.

Continuing education credits for physicians, psychologists and social workers have been applied for.

PLENARY SESSIONS

Plenary sessions will reflect themes central to the perspective of the National Center for Clinical Infant Programs. This perspective emphasizes: 1) the importance of allocating public and private resources to implement approaches known to be effective in strengthening young children and families; 2) the interaction and intersection of multiple lines of development in the growing infant or toddler; 3) the importance of relationships—between the baby and its partners, among family members, and between the family and professionals; and 4) the fruitful interaction between research and practice.

Friday afternoon, December 1

Opening plenary session: **Promises to keep: Learning from the 80's, facing the 90's—Lisbeth B. Schorr,** Harvard University and **Robert Mercer,** Chairman of the Board, Goodyear Tire and Rubber Company, retired; Chair: **T. Berry Brazelton, M.D.,** President, National Center for Clinical Infant Programs; Moderator: **Irving B. Harris,** Pittway Corporation, Chicago.

Saturday morning, December 2

Plenary session: **Language and communication in the context of emotional development in infancy and early childhood—Barry M. Prizant, Ph.D.,** Emma Pendleton Bradley Hospital, East Providence, Rhode Island; **Lee K.S. McLean, Ph.D.,** University of Kansas; **David E. Yoder, Ph.D.,** University of North Carolina, Chapel Hill; Chair: **Stanley I. Greenspan, M.D.,** George Washington University School of Medicine

Luncheon, Saturday, December 2

Dialogue: **Strengthening relationships through relationships—Ann Turnbull, Ph.D.,** University of Kansas; **Kathryn Barnard, Ph.D., R.N.,** University of Washington; **Jeree Pawl, Ph.D.,** San Francisco General Hospital, University of California, San Francisco; Moderator: **Arnold Sameroff, Ph.D.,** Brown University School of Medicine

Saturday afternoon, December 2

Plenary session: **The promise of fatherhood: Fathers in their relationships with infants, toddlers and service providers—Philip Davis, Ph.D.,** Nevada Specially Trained Effective Parents; **Dorothy Henderson, M.S.W.,** Harlem Hospital, New York City; **James Levine,** Bank Street College of Education, New York City; Chair: **Kyle Pruett, M.D.,** Yale Child Study Center

Sunday morning, December 3

Plenary session: **Clinically relevant research with special populations of parents and young children—Alicia Lieberman, Ph.D.,** San Francisco General Hospital, University of California, San Francisco; **Dolores Norton, Ph.D.,** University of Chicago; **Byron Egeland, Ph.D.** University of Minnesota; Chair: **Joy Osofsky, Ph.D.,** Louisiana State University Medical Center

THURSDAY/FRIDAY PRE-INSTITUTE SEMINARS

A new feature of the 1989 National Training Institute will be three pre-institute seminars beginning on Thursday afternoon, November 30, 1-5 p.m., and continuing on Friday morning, December 1, 9-11:30 a.m. The two-session format has been planned not only to allow for exploration of complex issues in some depth but also to give participants a chance to continue discussions informally on Thursday evening.

Pre-registration is required.

A. Clinical approaches to drug-exposed infants and their substance-abusing families

Substance abuse among parents of infants and toddlers is a phenomenon so widespread that almost any practitioner is likely to encounter the effects of prenatal and postnatal exposure to drugs, alcohol and tobacco. This seminar will summarize the data that are most clinically relevant to strengthening the capacities of parents and protecting and supporting the development of young children. Specific prenatal, perinatal, and early childhood intervention approaches will be discussed, with implications for both services targeted toward substance-abusing families and for more general infant/family programs.

Faculty: **Barry Zuckerman, M.D.,** Boston City Hospital and **Diana Kronstadt, Ph.D.,** Far West Laboratory for Educational Research and Development, Sausalito, California, moderators; **Lynn Yonekura, M.D.,** Harbor UCLA Medical Center; **Dan Griffith, Ph.D.,** Perinatal Center for Chemical Dependence, Chicago, IL; **Nika St. Claire, M.S.,** Children's Hospital, Oakland, CA; **Leila Beckwith, Ph.D.** and **Carol Rodning, Ph.D.,** University of California, Los Angeles.

B. Issues of clinical supervision in infant/family programs

Good supervision trains and supports line staff and is essential to achieving and maintaining high quality services. Yet few supervisors themselves receive training or support as they undertake the supervisory tasks unique to programs addressing the developmental needs of infants, toddlers and their families.

This seminar will look at two levels of supervision: The needs of supervisors and the functions of supervision for line staff and program participants. Issues to be examined include multiple roles of supervision, including supplementing knowledge and technical skills and providing support; the use of clinicians' emotional responses to families; and the importance of interpersonal process between supervisor and supervisee. The seminar will draw on a group process model, developed at Erikson Institute, Chicago, for training and supporting directors and supervisors of infant/family programs.

Registration is limited to 50. Contributions from seminar participants regarding their own experience will be encouraged.

Faculty: **Judith Bertacchi, M.Ed., S.W.** the Virginia Frank Child Development Center of the Jewish Family and Community Service, Chicago; **Judith Perkarsky, Ph.D.,** San Francisco General Hospital, University of California, San Francisco; **Frances Stott, Ph.D.** Erikson Institute, Chicago.

C. Comprehensive, intensive psychotherapeutic approaches and techniques for early interventionists to address concurrent emotional, language, and/or motor problems in infants and young children

This seminar will discuss intensive psychotherapeutic clinical work with infants and young children who present with a combination of therapeutic challenges, including receptive and expressive language delays, fine and/or gross motor delays, and emotional and social difficulties. In-depth case presentations as well as theoretical discussions will elaborate principles to help seminar attendees facilitate the overall development of infants and toddlers who face these challenges. Discussion will emphasize ways in which emotional and social development, and psychotherapeutic efforts enhance growth in these domains, can serve as a catalyst and organizer for simultaneous language and motor development. The seminar will also explore how members of a therapeutic team, including specialists in speech and language, motor, intellectual, and emotional development, can organize and integrate their individual insights and approaches.

Faculty: **Stanley Greenspan, M.D.,** George Washington University School of Medicine; **Serena Wieder, Ph.D.,** consultation and private practice, Silver Spring, MD; **Carolyn Eichberg, Ph.D.,** Regional Center for Infants and Young Children, Rockville, MD: **Barbara Kalmanson, Ph.D.,** Infant-Parent Program, San Francisco General Hospital; **Stephen Seligman, D.M.H.;** Infant-Parent Program, San Francisco General Hospital.

FRIDAY MORNING PRE-INSTITUTE SEMINARS

These sessions will take place on Friday morning, December 1 from 9-11:30 a.m. Pre-registration is required.

D. Funding opportunities for infant/family research and service programs—Irving B. Harris, Pittway Corporation Charitable Foundation; **Shelby Miller,** Ford Foundation; **James Hamilton,** OSERS, U.S. Department of Education; and other representatives of private foundations and federal agencies

E. Finding public and private funding for families with special needs infants and toddlers—David Chavkin, J.D., National Center for Clinical Infant Programs, and **Julianne Beckett, M.A.,** Maternal and Child Health Resource Center, University of Iowa

F. Frontiers of Infant/Toddler Day Care Research—Sarah L. Friedman, Ph.D., National Institute of Child Health and Human Development, moderator; **Bettye Caldwell, Ph.D.,** University of Arkansas; **Gilda Morelli, Ph.D.,** University of Utah; **Deborah Phillips, Ph.D.,** University of Virginia; **Henry Ricciutti, Ph.D.,** Cornell University; **Edward Tronick, Ph.D.,** Children's Hospital Medical Center, Boston, Massachusetts

G. Mental health consultation to child care providers—Sonya Bemporad, M.S., CSW/ACP—Child Care Dallas; **Kadija Johnston, M.S.W.,** Infant-Parent Program, San Francisco General Hospital; **Elizabeth Muir and Elizabeth Tuters, M.S.W.,** C.M. Hincks Institute, Toronto

H. Addressing issues of emotional development in primary health care settings—Janice Abarbanel, Ph.D., private practice, Washington, D.C.; **Robert McDowell, M.D.,** private practice, Washington, D.C.; **Susan Partridge, Ph.D.,** Project AIMS, University of Southern Maine; **Donna Wittmer, Ph.D.,** Onandoga Nation, Syracuse, New York

I. Family Administered Neonatal Activities (FANA): Using psychotherapeutic principles and Brazelton concepts to support parents of newborns—Ida Cardone, Ph.D., and **Linda Gilkerson, Ph.D.,** Evanston Hospital, Evanston, Illinois

J. Fussy babies: Assessment and treatment of sensory emotional and attentional problems in infancy—Georgia DiGangi, OTR, Regional Center for Infants and Young Children, Rockville, Maryland

K. Involving fathers in early intervention and family support programs: issues and strategies—Philip Davis, Ph.D., Nevada Specially Trained Effective Parents, Reno, Nevada and **Larnie Jones,** Family Focus/Our Place, Evanston, Illinois

L. Recruiting, training and retaining paraprofessionals in infant/family programs—Robert Halpern, Ph.D., Erikson Institute, Chicago; **Yvonne Jeffries, DSW,** Chicago, Illinois; **Candice Percansky, M.A.**—Ounce of Prevention Fund, Illinois

M. Guidelines for identification and assessment of developmentally vulnerable infants—Samuel Meisels, Ed.D.—University of Michigan, Ann Arbor; **Sally Provence, M.D.,** Yale Child Study Center; **Joyce Lindgren, R.N., M.P.H.,** Minneapolis, Minnesota; **Eleanor Szanton, Ph.D.,** National Center for Clinical Infant Programs

N. Individualized Family Service Plans: The struggle for excellence—Nancy DiVenere, B.A., Interagency Coordinating Council, Vermont; **Corinne Garland, Ph.D.** Child Development Resources, Lightfoot, Virginia; **Mary McGonigel,** Association for the Care of Children's Health, Washington, D.C.; **G. Gordon Williamson, Ph.D., OTR,** John F. Kennedy Medical Center, Edison, New Jersey

Note: Registrants are invited to suggest particular IFSP issues they would like to see addressed by the panel. Write questions/topics on a separate sheet marked "IFSP Seminar," attach to registration form, and submit no later than September 18, 1989.

O. Issues and approaches in providing mental health services for infants and toddlers under P.L. 99-457—Judith Katz-Leavy, Child and Adolescent Service Program, National Institute of Mental Health; **Paula Clarke, Ph.D.**—Division of Mental Health, Mental Retardation and Substance Abuse Services, Department of Human Resources, North Carolina; **Edward Hinckley,** Department of Mental Health and Mental Retardation, Maine; **Janet Martner, M.S.W.,** Georgetown University Child Development Center

P. Early intervention with culturally diverse families of infants and toddlers with disabilities—Penny Anderson, M.A.—National Center for Clinical Infant Programs; **Sam Chan, Ph.D.**—University Affiliated Program, Children's Hospital, Los Angeles; **Justine Strickland,** Interagency Coordinating Council, New York State

Q. The inner life of the young child: technical and theoretical problems of long-term out-patient psychotherapeutic intervention with young atypical children—Kirsten Dahl, Ph.D., Steven Marans, M.S.W., and **Kyle Pruett, M.D.,** Yale Child Study Center. For experienced practitioners.

R. Traditional and emerging approaches to the diagnosis of problems in infants and young children—Stanley Greenspan, M.D., George Washington University School of Medicine and Chair, Diagnostic Classification Committee of the National Center for Clinical Infant Programs, and other members of the Committee. For experienced practitioners.

SPECIAL INTEREST SESSIONS

Invited special interest sessions presenters will include **Albert J. Solnit, M.D.** and **Barbara Nordhaus, M.S.W.,** Yale Child Study Center; **G. Gordon Williamson, Ph.D., OTR** John F. Kennedy Medical Center, Edison, New Jersey; **Kathryn Barnard, Ph.D., R.N., Georgina Sumner, M.N.,** and **Robin Thomas, Ph.D.,** University of Washington; **Jack Shonkoff, M.D.,** and **Penny Hauser-Cram, Ed.D.,** University of Massachusetts Medical School; **Arthur Kohrman, M.D.,** La Rabida Hospital, Chicago; **Victoria Levin, M.S.W.,** National Institute of Mental Health; **Peter Mangione, Ph.D.,** Far West Laboratory for Educational Research and Development, Sausalito, CA: **Susan McDonough, Ph.D.,** Brown University, Program in Medicine and Bradley Hospital; **Michael Trout,** Infant-parent Institute, Champaign, IL; **Rebecca Shahmoon Shanok, Ph.D., LCSW,** Jewish Board of Family and Children's Services, New York City; **Susan Theut, M.D.,** Georgetown University School of Medicine and Veterans Administration Medical Center, Washington, D.C.; **Thomas Kochanek, Ph.D.,** Rhode Island College. **Maria Finn-Stevenson, Ph.D.,** Bush Center in Child Development and Social Policy, Yale University; **David Caruso, Ph.D.,** Purdue University; **Rae Grad, R.N., Ph.D.,** National Commission to Prevent National Mortality; **Pat Ward,** National Council of Jewish Women; and **Gloria Harbin, Ph.D.,** Carolina Child and Family Policy Institute.

On Friday afternoon, Saturday morning and Saturday afternoon approximately 30 1½ hour symposia and case presentations selected from a nationwide call for proposals, will be offered.

A Friday evening poster session/reception and a Sunday morning poster session/continental breakfast will feature selected presentations describing research findings, service delivery models, public education initiatives, tools for assessment and evaluation, and approaches to parent and professional training.

On Saturday evening and Sunday morning, special 45-minute sessions will illustrate the use of video in pre-service and in-service training for professionals, parents and paraprofessionals.

REGISTRATION INFORMATION

Registration is limited. The registration fee of $160 will cover admission to all institute sessions, including the Friday evening poster session/reception and the Sunday morning poster session/continental breakfast.

An early registration fee of $135 is offered to those whose registration for the training institute is received before September 18, 1989. Any cancellation must be made in writing, accompanied by a self-addressed envelope. For cancellations received after November 10, $25 will be deducted from the refund. No refunds will be given for cancellations after November 24 unless individually approved by the conference coordinator.

Pre-institute seminars will be held on Thursday afternoon, November 30 from 1-5 p.m. and on Friday morning, December 1 from 9-11:30 a.m. A registration fee of $50 will be charged for the Thursday/Friday seminars (A, B, and C). A fee of $25 will be charged for the Friday morning seminars (D-R). Registration for each seminar is limited, and assignments will be made on a first come first served basis. First, second and third choices should be indicated on the registration form.

A luncheon for institute participants will be held on Saturday, December 2. Tickets will cost $22. Participants preferring to have lunch on their own in the neighborhood of the hotel will be provided with seating for the luncheon dialogue.

Old Town Travel, Alexandria, Virginia, (800-368-3005) has agreed to assist National Training Institute participants in obtaining the lowest possible airfares between their home cities and Washington, D.C.

A grant from the A.L. Mailman Family Foundation, makes it possible to waive registration for a limited number of representatives of service programs who would otherwise be unable to attend the institute. **Inquiries must be received by August 1—see registration form.**

FACULTY

Janice Abarbanel
Penny Anderson
Kathryn Barnard
Julianne Beckett
Leila Beckwith
Sonya Bemporad
Judith Bertacchi
T. Berry Brazelton
Bettye Caldwell
Ida Cardone
David Caruso
Sam Chan
David Chavkin
Paula Clarke
Kirsten Dahl
Philip Davis
Georgia DiGangi
Nancy DiVenere
Byron Egeland
Carolyn Eichberg
Maria Finn-Stevenson
Sarah Friedman
Corinne Garland
Linda Gilkerson
Rae Grad
Stanley Greenspan
Dan Griffith
Robert Halpern
James Hamilton
Gloria Harbin
Irving B. Harris
Penny Hauser-Cram
Dorothy Henderson
Edward Hinckley
Yvonne Jeffries
Larnie Jones
Kadija Johnston
Barbara Kalmanson
Judith Katz-Leavy
Thomas Kochanek
Arthur Kohrman
Anneliese Korner
Diana Kronstadt
J. Ronald Lally
Victoria Levin
James Levine
Alicia Lieberman
Joyce Lindgren
Peter Mangione
Steven Marans
Janet Martner
Susan McDonough
Robert McDowell
Mary McGonigel
Lee K.S. McLean
Samuel Meisels
Robert Mercer
Shelby Miller
Gilda Morelli
Elizabeth Muir
Barbara Nordhaus
Dolores Norton
Joy Osofsky
Susan Partridge
Jeree Pawl
Judith Pekarsky
Candice Percansky
Deborah Phillips
Barry Prizant
Sally Provence
Kyle Pruett
Henry Ricciutti
Carol Rodning
Arnold Sameroff
Lisbeth Schorr
Stephen Seligman
Rebecca Shahmoon Shanok
Jack Shonkoff
Albert J. Solnit
Nika St. Claire
Frances Stott
Justine Strickland
Georgina Sumner
Eleanor Szanton
Susan Theut
Robin Thomas
Edward Tronick
Michael Trout
Ann Turnbull
Elizabeth Tuters
Pat Ward
Serena Wieder
G. Gordon Williamson
Donna Wittmer
David Yoder
Lynn Yonekura
Barry Zuckerman

REGISTRATION FORM

☐ I wish to register for "Promises to Keep," NCCIP's Sixth Biennial National Training Institute ($160; $135 until September 18) $ ______

☐ Please enroll me in the two-session Thursday/Friday pre-institute seminar indicated below. (Note: a participant may attend either a Thursday/Friday or a Friday pre-institute seminar) ($50) $ ______

____ **A.** Clinical approaches to drug-exposed infants and their substance-abusing families
____ **B.** Issues of clinical supervision in infant/family program
____ **C.** Comprehensive psychotherapeutic approaches to infants with multiple handicaps

☐ Please enroll me in the 2½ hour Friday morning pre-institute seminar indicated below (give first, second and third choice) ($25) $ ______

____ **D.** Funding opportunities for research and services
____ **E.** Public and private funding for special needs families
____ **F.** Frontiers of infant day care research
____ **G.** Mental health consultation to child care
____ **H.** Addressing emotional development in primary health care
____ **I.** The Family Administered Neonatal Activities (FANA) approach
____ **J.** Fussy babies
____ **K.** Involving fathers in infant/family programs
____ **L.** Recruiting, training and retaining paraprofessionals
____ **M.** Guidelines for identification and asessment of developmentally vulnerable infants
____ **N.** IFSPs: The struggle for excellence
____ **O.** Infant/toddler mental health services under P.L. 99-457
____ **P.** Early intervention with culturally diverse families
____ **Q.** The inner life of the young child
____ **R.** Diagnosis of infants and young children

☐ I wish to attend the luncheon on Saturday, December 2, ($22) $ ______

Total Amount $ ______

☐ Please send me scholarship information. (I understand that efforts have been made to keep registration fees as low as possible and that scholarship funds are extremely limited).

Please enclose a stamped, self-addressed envelope with this form. Confirmation will be sent for all registrations received by November 17.

☐ Enclosed is a check, payable to NCCIP for $ ______

☐ Charge to ☐ Master Card ☐ Visa

Account # ______

Credit card expiration date ______

Signature ______
required if credit card is used)

☐ I wish to receive a registration card from the J.W. Marriott Hotel (conference rates $85 single or $95 double/night)

☐ I wish to receive a registration card from Washington Plaza Hotel ($70 single or $80 double/night)

Name ______

Address ______

______

City ______ State ______ Zip ______

Professional discipline, if applicable ______

Job title or description, if applicable ______

Return to Pat Guwang
NCCIP, 733 15th Street, N.W., Suite 912
Washington, D.C. 20005
(202) 347-0308

Employer ID #52-1152319

Publications

of the National Center for Clinical Infant Programs

The National Center for Clinical Infant Programs (NCCIP) produces a variety of written materials for practitioners, policymakers and parents concerned about the development of children and families in the first three years of life. Because publications are distributed through several sources, please follow ordering instructions carefully.

National Center for Clinical Infant Programs

The following publications are available from the
National Center for Clinical Infant Programs
733 15th Street, N.W., Suite 912,
Washington, D.C. 20005,
tel: (202) 347-0308.

Zero to Three

5 issues/year	1 year	$18.00
	2 years	$35.00
	3 years	$45.00

Written for professionals working with infants, toddlers and their families, **Zero to Three** includes reports on research in progress, profiles of clinical programs, discussion of current issues in the field, and news of government and private activities, conferences, and publications. Each issue averages 30 pages. Back issues (from Sept. 1980) and Index $4.00/copy.

Policy-relevant research and analysis

Infants Can't Wait, 1986 $6.50/set.

Reviews the developmental tasks and needs of infants and toddlers, describes support available in this country for their healthy development, and documents needs which are not being met. Proposes two major initiatives to ensure basic and specialized services for young children and their families, as well as strategies for implementation at the federal, state and local levels.

Infants Can't Wait: The Numbers, 1986.

Companion volume to **Infants Can't Wait.** Documents statistically the birth of infants, the circumstances of their families, risks to their health and lives in the first years of life, their family and community environments, and the sources of their health care.

Maternal Health and Infant Survival: *An Analysis of Medical and Social Services to Pregnant Women, Newborns and Their Families in Ten European Countries, with implications for Policy and Practice in the United States,* C. Arden Miller, M.D., 1987 $6.00/copy. Bulk rate available.

Analyzes health care and social supports for pregnant women and their families in ten western European countries with infant mortality rates lower than those in the United States. Analysis, which has major implications for U.S. health policy, reveals a set of strategies which, if implemented, could lead to reduced rates of infant mortality and low birth weight in the United States, and would ultimately reduce public health care expenditures.

Identifying and Assessing Young Disabled and Developmentally Vulnerable Children and Their Families: *Recommended Guidelines,* Samuel J. Meisels and the Task Force on Screening and Assessment of the National Early Childhood Technical Assistance System (NEC*TAS) (in press).

Suggests guidelines for the identification and assessment of children who should participate in programs related to the infant-toddler (Part H) and the preschool (Section 619) components of P.L. 99-547. Focuses on the rationale, core components, and guidelines for establishing a system of screening and assessing disabled and developmentally vulnerable children, birth through age five, and their families.

Child care issues

Finding the Best Care for Your Infant or Toddler, Laura L. Dittmann, 1985. No charge for single copies.

Provides parents with information on elements of good care for infants and toddlers, and answers common questions about choosing care. A brochure published jointly by the National Center for Clinical Infant Programs and the National Association for the Education of Young Children.

Infants, Families and Child Care: Toward a Research Agenda, 1988 $1.50/copy.

Assists the general reader in understanding the vocabulary, assumptions and outstanding research questions involved in infant day care research. Describes areas of consensus reached

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ostracized by their families and shut out by the very systems that are supposed to help them.

The case manager's role often has been one of educating service providers about risk factors and what can and can not happen to them if they provide day care or homemaker services to families. It has been the case manager's task to stimulate (i.e. hound or nag) staff in social agencies to provide services to families. In addition to their advocacy on behalf of families like Jill's, the case managers have also acted to protect their civil rights, especially around breaches of confidentiality and disclosure of their HIV status.

Maintaining attention on the needs of each family member when organizing and delivering services to families has, in many cases altered how services are introduced. Often a service that seems appropriate and logical (like family day care for the twins) is not what the family wants, so other alternatives must be explored. Knowing who is in the family and what their individual needs are has helped the case manager to design interventions that are meaningful and manageable.

Working with families in their homes improves the quality of service delivery. When a case manager visits with families on their own turf, it demonstrates a belief in the value and worth of family menbers ("I am important enough for them to come to me"). It also gives the case manager a clear view of the family's environment, needs and interactions, as well as an intimate knowledge of family resources and any factors that impede the family's ability to receive help.

Often the factors that impede a family's ability to use available services require concrete intervention. Helping families remove these barriers has been a large part of the case management services provided by WIN. For example, arranging transportation to school and to and from the after-school program meant that Jill's children could use the services available to them, and Jill could feel confident that her children were safe. Helping Jill arrange repair of her washing machine was a useful and meaningful intervention that has significant impact of the quality of her family's life.

When HIV infection is present, case managers have spent a great deal of time on indirect services, calling (and re-calling) a number of places to arrange services, following up to ensure that services are in place, and then starting all over again when services fall apart. These tasks require impeccable management skills and sophisticated political expertise. Many service providers, agencies and institutions in the community feel it is not thier job to deal with the HIV infected. Others feel that they should be the only provider of services. The case managers have expressed the feeling that sometimes the systems require more work than the clients.

Not that the clients are so easy. Working with these families has required stamina, fortitude and creativity. The case managers receive daily team support, weekly supervision, and monthly consultation from the transagency board, yet they have often felt overwhelmed, overburdened and powerless. They visit people in their homes in dangerous neighborhoods where shootings occur daily. They work with people who, when they are using drugs, behave unpredictably, are not home for scheduled appointments, and are continually in crisis. As a result of the difficulty of the work, staff turnover has been high, and morale has sometimes been low.

Although the efforts of the WIN staff and the transagency model have resulted in improved delivery of services for the families, there are obvious gaps in services to these families which we have been able to identify, but not remedy. One of the most glaring gaps in service is the shortage of center-based day care facilities. Day care for HIV-infected infants and toddlers would not only provide the children with social outlets and stimulation, but would also provide their caregivers with much needed respite care, possibly forestalling family breakup.

There is a glaring need for a flexible, family-focused continuum of services which anticipates and responds to families' increasing or diminishing needs, and which begins at the point of diagnosis, not when the family is already in a crisis which might have been prevented. No one program, hospital or agency can possibly provide families with all the services they need. The current service delivery system is not designed to accommodate the insonsistencies and behaviors of drug-addicted and disenfranchised people. Services need to allow for periodic hospital admissions, and must ebb and flow without requiring major paperwork and bureaucratic manipulation in order to restore them. Such services include home health support, home-based nursing care, round-the-clock home support, transportation on request to and from hospitals and health centers, (Jill walked the 3 miles home from the hospital when she was discharged because she could not afford a cab), and round-the-clock support for meal preparation, shopping, errands, and family-focused buddy or volunteer services.

The healthy children of infected parents are carrying an inordinate burden of responsibility, yet they have no identified support system. Often they feel compelled to maintain secrecy about the nature of their parent's or sibling's illness. Sometimes they are not told directly what is happening and what to expect, compounding their fear, guilt, sense of responsibility and sadness. Yet, these children often hold the families together, assuming an adult burden of care for their sick parents and their younger siblings.

The experiences of Project WIN demonstrate that families affected by HIV infection can be served in their homes and communities. The community can respond to the needs of families and deliver coordinated services, making it possible for families to use hospital beds only for treatment of acute episodes.

Promoting the Health and Development of Drug-Exposed Infants through a Comprehensive Clinic Model

by

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What new models must we create to provide optimal health and developmental outcome for drug-exposed infants? Pioneering efforts have been made to address the special needs of chemically dependent mothers by programs and individuals in Boston, New York, Philadelphia, Chicago, Houston and elsewhere.[1] The discussion that follows represents our own ongoing attempts to answer this question, and the many questions that flow from it.

Efforts to promote the health of drug-exposed babies must address at least three major areas:

- **Special needs of the infant:** These include prematurity, symptoms of withdrawal, and neuromaturational problems that are among the medical effects of drug exposure in utero.
- **Special needs of the mother:** Foremost among these is drug treatment, because the mother's ability to make use of other services may depend upon the success of this intervention. (Most studies indicate that about half of addicted mothers who are not in any form of drug treatment lose custody of their children by one year of age. [Lawson and Wilson, 1980; Merrick, 1985; Chan, 1986]). Help in securing housing, food, health care and transportation is essential. So is emotional support.
- **Special needs of the high risk dyad and family:** Many factors conspire to frustrate the formation of positive relationships between drug-exposed infants and their mothers, including the prematurity and/or drug withdrawal of the babies, insecurity and lack of past nurturing of the mothers, and disorganized lifestyles that make it hard for parents to focus on their babies. Both mother and infant are likely to be excessively "needy," with difficulty in coping with even moderate levels of frustration, anxiety or tension. Social supports must be sought or provided. Families need basic information about child development and models of age-appropriate expectations. For selected families, intensive infant-parent psychotherapy offers the promise of healing deeply troubled relationships.

Some of these services are available in some form in some of our communities. But an addicted mother is unlikely to keep separate appointments with a pediatrician, a drug counselor, a social worker and a psychologist. To meet the needs of drug-exposed infants and drug-using mothers, these service providers must work physically under the same roof and must work therapeutically as a unit as well. Our service delivery model must reflect our understanding that the health and developmental outcome of drug-exposed children depends upon complex interactions between biology and social context.

The C.A.R.E. (Chemical Addiction Recovery Efforts) Clinic, part of the Center for the Vulnerable Child at Children's Hospital, Oakland, California represents a beginning attempt to address the needs of this population.

How did the C.A.R.E. Clinic start?

A group of concerned health professionals began the C.A.R.E. Clinic with no special resources other than funding for a half-time case manager knowledgeable about chemical dependency. Initially, routine pediatric care for drug-exposed babies was offered in an outpatient clinic of our children's hospital. Women were self-referred, sent from the emergency department, or referred from other clinics. The case manager made home visits, assisted with material needs, and provided ongoing emotional support. Her enthusiasm, skill and therapeutic flexibility were crucial in engaging women and building the program. Services were added gradually as we worked toward our vision of a setting that could address health, developmental and parent-child issues.

Who are the clinic's clients?

Chemically dependent mothers (and sometimes fathers) and their drug-exposed infants come to the clinic. We try to involve the mother as soon after delivery as possible, or even prenatally. Most mothers have a history of polydrug abuse, with cocaine, marijuana and alcohol predominating. Prostitution, criminal activity, physical assault, homelessness, and a history of childhood abuse or neglect are common experiences.

The women we see have seldom had positive experiences of being mothered nor do they have current support for their own mothering. Many grew up in dysfunctional and/or chemically dependent families where their needs as infants were met inconsistently. As Coppopillo (1975) notes, this experience may lead to a fixation on objects as a source of gratification, leading to subsequent problems with human relationships. Many addicted mothers have difficulty recognizing their infants' needs: they do not know how to take care of themselves, let alone an irritable or somnolent baby.

Who are the caregivers?

A therapist/case manager with special expertise in the field of chemical dependency, a pediatrician, and a nurse staff the C.A.R.E. clinic. Consultation with a developmental pediatrician, a nutritionist, a psychiatrist, an AIDS specialist, and a psychologist/infant-parent specialist is available. It is our strong feeling, however, that caregivers' professional degrees matter far less than their personal qualities. Caregivers must be willing to confront and discard their own prejudices in order to be effective. They must have both compassion and respect for the families with whom they work, seeing the addicted mother as a person capable of growth and change. Their attitudes help to create an environment which supports that growth in chemically dependent women who are used to being scorned, judged, rejected and viewed as incapable of mothering.

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[1] These efforts include the Perinatal Center for Chemical Dependence at Northwestern University begun by Ira Chasnoff and his colleagues, the Pregnant Addicts and Addicted Mothers Program in New York led by Nina Lief, and studies by Wilson and colleagues at Baylor College of Medicine and Houston City Hospital, Finnegan and Kaltenback in Philadelphia, and Zuckerman at Boston City Hospital.

Although we use a case management model, it is an adapted model since brokering services is rarely feasible. The case manager/therapist might be more accurately described as a milieu therapist, who uses every opportunity to establish a therapeutic alliance, make interventions with the mother, and support her in her efforts to recover. The role of the case manager may vary depending on the needs of the individual client. The case manager may serve as problem solver, role model, advocate, broker, assessor, planner, service monitor, record keeper, therapist, collaborator and detective (one client changed her address three times and her telephone number five times in an eight-month period).

What services are offered?

The C.A.R.E. Clinic offers **medical** services, including routine pediatric care, anticipatory guidance, developmental assessment, parenting education, and illness visits. Among the material aids we provide are formula, diapers, used clothing in good condition, baby blankets, toys, books, and "snuggli" carriers to promote bonding. (As many mothers tend to be materialistically oriented, it is helpful to provide tangible items until a relationship with its own satisfactions is established.) **Support** is available in the form of weekly participant group meetings, individual counseling, drop-in and telephone availability of staff, home visits, family therapy, and referral to 12 step meetings, such as Cocaine Anonymous. **Social events** include holiday parties, picnics, birthday parties, and baby showers. Chemically dependent women may have lost the ability to have fun while "clean" and sober, or may never have had the experience and need opportunities to practice this skill.

Consultation occurs with both other hospital-based providers and with the community. Hospital consultation may include a developmental pediatrician, nutritionist, infectious disease specialist, and parent-infant therapist. Within the community we consult with Child Protective Services, the Department of Probation, Public Health Nursing and private drug and alcohol treatment providers. We are also active in providing training to physicians, nurses, social services and other related health professionals.

What services will be added?

We have recently expanded the C.A.R.E. Clinic to include a house in the community that will provide a place for daily drop-in services, additional parenting groups, addiction recovery meetings, and general support in a nurturing "center" akin to that so eloquently described in *Infants in Multirisk Families* (Greenspan, et.al., 1987). The house will provide an oasis for families in crisis and respite from neighborhood stressors.

What about compliance?

According to the conventional wisdom, chemically dependent women never keep appointments. Yet our program slots are full to overflowing each week. We like to think that a process of attachment needs to occur between the high risk family and service providers, much as it does between parent and child. There will be false starts. There may be suspicion and mistrust. Basic survival needs of the family must be met, and their cues must be listened for and interpreted. With patience and flexibility, a relationship is built, based on trust, consistency and loving concern. "Show rates" tend to reflect both the state of the relationship and whether or not the family is in crisis. Sometimes Child Protective Services requirements or the mother's concern regarding the effect of drugs on her child can be used as leverage to initiate involvement until a more substantive connection can be made.

What has been accomplished?

The predominant pattern of pediatric care for this population at our hospital prior to establishing the clinic had been one of hit-or-miss, emergency room-centered drop-in visits. By contrast, 100 percent of the children now have primary pediatric care and anticipatory guidance provided, and are fully immunized. Developmental delays can be identified early and appropriate interventions initiated. We note consistent improvement in the addict-mothers' confidence and ability to parent, and more women are in the recovery process, abstaining from drug use for weeks to months at a time. As a result, mother-infant pairs remain intact and functional, with only two children being lost to the foster care system within the past two years.

What are our convictions?

We believe that it is in the best interests of both mother and child (and cost effective as well) to provide services that attempt to support their relationship rather than thrusting these infants into an already overloaded, deeply flawed foster care system. We are troubled by our awareness that the chemically dependent mother is held in contempt by her family, Child Protective Services staff, health professionals and society at large, and that her low self-esteem is confirmed daily by her interactions with "the system." We are distressed that so few resources have been allocated to treating these mothers and their children despite the great need.

We believe that giving birth is a unique and powerful time in a woman's life which can be used as a catalyst for healing herself and her baby. We are disheartened by the current national trend to criminalize women who use drugs and to use positive urine toxicologies alone as criteria for denying a mother custody of her young children. Any deficits or impairments caused by in utero exposure to drugs are, we believe, exacerbated by the effects of disruptive multiple placements and problems in attachment. Criminal and custody sanctions drive women away from centers of care. Women should not be afraid to enter health care facilities to receive the services they so desperately need. Comprehensive drug treatment and medical/social services should be made available to addicted women who are pregnant and should be continued after delivery. Only when these interventions fail should other alternatives be considered to safeguard the health and welfare of the child.

We believe that comprehensive care for the mother-infant pair will promote recovery for both the woman and her drug-exposed infant. Providers need to focus on more than the medical needs of the children and address the social and emotional needs of both infant and mother as well. It is past time to abandon the self-fulfilling prophecy that addicted mothers make bad mothers. Instead, we must believe that recovery is possible and that interventions can and do make a difference in the quality of life for all these vulnerable children.

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Addicted Infants and Their Mothers

by

Congressman George Miller, Chairman
Select Committee on Children, Youth, and Families
U.S. House of Representatives

Three years ago, witnesses warned the Select Committee on Children, Youth, and Families about a very serious problem: damage to women and their babies resulting from substances abuse during pregnancy.

Since that time, the epidemic of "crack" cocaine has exploded onto the American landscape. And it has become increasingly clear that pregnant women, infants, and young children are new casualties of this scourge.

The only known national estimate suggests that, in 1988, 11 percent of pregnant women used drugs during pregnancy, and some 375,000 newborns annually may be damaged by drug exposure. But, aside from this estimate and a few specialized studies, little is known about the extent of substance abuse or the nature of its impact on pregnant women and infants.

To understand this emerging phenomenon better, I asked my staff at the Select Committee to talk with hospitals in large metropolitan areas about their experiences. I released the results of this survey at hearings on April 27, 1989.

Our findings are profoundly disturbing. Not only do they confirm the escalation of drug exposure among newborns but they underscore the urgency of action on all fronts.

A detailed accounting of our findings follows. Major points include:

- Fifteen of the 18 hospitals surveyed reported 3 to 4 times as many drug-exposed births since 1985. In some hospitals, one in six of all newborns is born "hooked."
- Drug-exposed babies are more likely to be born prematurely and have low birthweight, dramatically raising their risk of infant mortality and childhood disability.
- Women who seek help during pregnancy cannot get it. Two-thirds of the hospitals reported that they had no place to refer substance-abusing pregnant women for treatment.
- Hospitals in Los Angeles and Washington, D.C. reported the reemergence of maternal death during labor and delivery—directly attributable to drug abuse during pregnancy.
- Eight hospitals reported growing numbers of "boarder" babies who remain in hospitals because their parents abandon or cannot care for them.

The broad brush picture painted by this survey illustrates the devastating impact of substance abuse on America's most vulnerable citizens. While the number of drug-exposed babies remains relatively small, they are among the most expensive babies we care for. And, these children have the ability to swamp every system involved with their care—hospitals, child protective services, foster care, and schools.

Hospitals we surveyed cautioned that their estimates vastly undercount the number of women and children affected. They indicated, as well, that these newborns stay in the hospital up to 13 days longer than healthy infants, at a cost which can reach nearly $1800 a day.

These problems are no longer confined to inner cities. In my suburban district in California, 40 babies a month are born drug-exposed, and these children now represent 60-75% of foster care caseloads in the county.

Congress has recently targetted additional resources to prevent and treat drug abuse during pregancy. But as our evidence from the front lines demonstrates, these efforts remain too slow and too few.

At the Select Committee's hearings, testimony was given by nurses, doctors, educators and others who see daily the implications of this crisis for families and communities across the country. What these witnesses graphically described symbolizes, in my view, a tragic effect of a decade of national neglect. This is a problem that demands not only greater exploration but much more dedication to remedies that work.

Addicted Infants and Their Mothers: A Survey

Introduction

To understand the scope of addictions among pregnant women and the effects on their children, I asked the staff of the Select Committee on Children, Youth and Families to sample the experiences of major municipal hospitals around the country.

In response to my request, the staff conducted a telephone survey of 14 public and 4 private hospitals in fifteen cities, including nine of the most populous cities. (Cities in which hospitals were surveyed include: Boston, Chicago, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, New York City, Oakland, Philadelphia, Phoenix, San Antonio, Seattle and the District of Columbia.) Interviews with obstetricians and gynecologists, neonatologists, social workers and administrators in one or two hospitals in each of these cities provided the basis for our observations. While the study is by no means definitive, nor is the sample scientific, the findings which emerge offer a snapshot of the prevalence and impact of drug addiction on pregnant women and their newborn infants.

The survey questions centered on trends in births of drug-exposed infants, whether and how infants and/or pregnant women are screened for illegal substances, length of hospital stay, and costs associated with substance-exposed infants. Staff requested data on the following illegal substances individually or in combination: cocaine, heroin, PCP, marijuana, or any other measured. Although the survey focused principally on illegal drug abuse, experts agree that alcohol and/or tobacco use often accompany other drug use and pose serious risks of poor birth outcomes. Data provided on alcohol and/or tobacco use were also recorded.

While the newness of the problems, their rapid increase, and lack of uniform data prevent our obtaining a precise count of drug-exposed births, the experiences of hospital staff are undeniably and remarkably comparable—and their observations and concerns are similar on several points.

Principal Findings

Trends in births of drug-exposed infants

1. Of the 18 hospitals surveyed, 15 (14 public and 1 private) reported an increase in the incidence of substance abuse during pregnancy and the number of drug-exposed births since 1985. (See Notes 1a, b, c.)

Eight hospitals surveyed had trend data available:

- A hospital in **Dallas:** based on maternal histories, the number of drug-exposed newborns increased from 65 of approximately 3410 total births to 192 of 3360 total births between 10-12/1987 and 10-12/1988.
- A hospital in **Denver:** based on maternal histories, the number of drug-exposed newborns increased from 32 of 2875 total births to 115 of 2924 total births between 1985 and 1988.
- A hospital in **New York City:** based on newborn toxic screening, the number of drug-exposed newborns increased from 12%-13% of 2900-3000 total births in 1985 to 15% of 2900-3000 total births in 1988.
- A hospital in **Oakland:** based on newborn toxic screening, the number of drug-exposed newborns increased from 6% to 18% of the approximate 2400 total births per year between 1985 and 1988.
- A hospital in **Philadelphia:** based on newborn toxic screening and maternal histories, the number of drug-exposed newborns increased from 4% of approximately 1078 total births in the period 7/1/87-12/31/87 to 15% of 1105 total births in the period 7/1/88 -12/31/88.
- A hospital in **Washington, DC:** based on newborn screening and maternal histories, the number of drug-exposed newborns increased from 5.7% of 1994 total births in 1985 to 18% of 1812 total births in 1988.
- A hospital in **Detroit:** based on maternal histories, the number of narcotics-exposed infants (which primarily reflects maternal cocaine use and, to a much lesser degree, heroin use) increased from 9.1% of 1111 total clinic births in 1985 to 10.4% of 1781 total clinic births in 1987.
- A hospital in **Houston:** based on maternal histories, the rate of drug-exposed infants admitted to the neonatal intensive care unit has increased from 1.73/100 to 4.9/100 between 7/1/86-6/30/87 and 7/1/87-6/30/88.

2. Of the 18 hospitals surveyed, 9 suggested that the number of drug-exposed infants and substance-abusing pregnant women were undercounted. According to these hospitals, the undercount can be attributed to maternal denial of drug use, lack of clinician sensitivity to indicators of drug use, and the inaccuracy of toxic screening, which has high false negatives and only detects substance use within the previous 24 hours.

- In a Miami prevalence study, only 27% of the pregnant women testing positive for drug use at labor and delivery had admitted drug use. (See Note 2)
- A pediatrician in a Detroit hospital reported that urine toxicologies only detect 37% of the positive drug-exposures because of the test's high rate of false negatives.

3. Hospital neonatologists and pediatricians cited similar physical and behavioral conditions of drug-exposed newborns: prematurity, low birthweight, hypertonicity, and low Apgar scores are frequent characteristics among newborns born to mothers who used drugs during pregnancy. (Survey data received may reflect single or polydrug assessment.)

- Hospitals in Detroit and Miami reported that approximately 1/3 of drug-abusing pregnant women had premature newborns (See Note 2.)
- A Washington, D.C. hospital reported that 18% of its drug-exposed newborns had low birthweights, as compared to 12% of the non-exposed newborns.

Trends among substance-abusing pregnant women

4. Hospitals commonly found that substance-abusing pregnant women frequently suffered abruptio placenta and unexplained hypertension. Two hospitals reported maternal death during labor and delivery.

- A Los Angeles hospital reported that 3 maternal deaths in 1988 were attributed to drug ingestion.
- A hospital in Washington, D.C. reported the re-emergence of maternal death associated with labor and delivery as a result of "crack" cocaine use.

5. 4 of the 18 hospitals surveyed stated concern about the increase in cases of venereal disease and increased risk of HIV infection among their patients, many of whom are substance-abusing women.

- A prevalence study of newborn drug-exposure at a New York hospital found a 495% increase in the number of reported syphilis cases among women between 1985 and 1988.
- Several hospitals mentioned concerns regarding the risk to drug-exposed newborns of becoming HIV-infected because of the prevalence of the virus among intravenous drug users.

6. Most of the hospitals surveyed reported that since 1980 "crack" cocaine has become the drug of choice.

- A hospital in Oakland reported that 90% of newborns with positive toxic screens showed cocaine exposure.
- In a Houston hospital, the percentage of pregnant substance abusers reporting cocaine use increased from 2% in 1980 to more than 80% in 1989.
- A Chicago two-week prevalence study found that, at labor and delivery, 55% of the women reporting drug abuse used cocaine.

7. Respondents from several hospitals mentioned that alcohol consumption is a significant part of the polydrug pattern of substance abuse among pregnant women.

- Based on maternal histories, a hospital in Detroit found that 11.5% of births over several months in 1988 were to women who reported alcohol consumption during pregnancy.

Health care for addicted pregnant women

8. 7 of the 18 hospitals surveyed reported that substance-abusing pregnant women were up to 4 times less likely to receive prenatal care than other women.

- According to a responding obstetrician at a Miami hospital, 30% of substance-abusing women do not obtain prenatal care compared with 15% of other women.
- A Dallas hospital reported that 50%-70% of substance-abusing pregnant women do not receive prenatal care compared with 15% of other women.

9. 12 of the 18 hospitals surveyed reported that they have no place to send pregnant women for drug treatment.

- For pregnant women addicted to cocaine in Boston, there are approximately 30 residential treatment slots in the city. At a hospital in Boston, according to maternal histories, 18% of the 1700 mothers delivering there use cocaine.
- A hospital in Los Angeles noted a 10 to 16 week waiting period for drug treatment, even for pregnant women.

Placement of drug-exposed infants

10. 8 of the 18 hospitals surveyed reported that drug-exposed newborns medically cleared for discharge regularly remain in the hospital for various reasons including the lack of available and appropriate foster care placement or delayed protective services evaluation.

- On a given day, a Miami hospital houses 20-30 "boarder" babies who may remain in the hospital for up to a month. The hospital attributed the high number, in part, to the effect of new state law which places all drug-exposed newborns under state custody, overwhelming the foster care system.

Hospital costs

11. Although no cost studies specific to drug-exposed babies have been conducted, 8 of the 18 hospitals surveyed referred to the high cost of care for low birthweight and sick babies, an increasing number of whom have been exposed to drugs. Often born prematurely or suffering withdrawal symptoms, drug-exposed newborns typically have longer stays in the hospital, frequently in the intensive care nursery (ICN).

- A Los Angeles hospital estimated the average cost of a drug-exposed newborn in the ICN is approximately $750/day for a mildly drug-exposed newborn and $1768/day for a severely affected infant.
- 8 of the 18 hospitals estimated that cocaine-exposed

newborns also tended to stay 1 to 13 days longer than healthy newborns, though not in special care.

12. 6 of the 18 hospitals mentioned a lack of resources to confront the problem of drug-exposed newborns. They cite the costs associated with drug screening, prevalence studies and "boarder" babies.

Notes

1.a. None of the 18 hospitals surveyed reported routinely screening all newborns or pregnant women for drug exposure. 15 of the 18 hospitals surveyed screen newborns if there are reasons to suspect drug-exposure, based on maternal history or report, or clinical signs. 8 of the 18 hospitals surveyed screen pregnant women if there are reasons to suspect drug abuse.

b. There is no uniformity in drug screening or data collection. That is, the way in which hospitals assess drug use and the resulting data bases vary hospital to hospital. This is to some extent due to the lack of adequate research protocols or agreement among medical and other experts as to the nature, appropriateness and consequences of such screening and/or reporting.

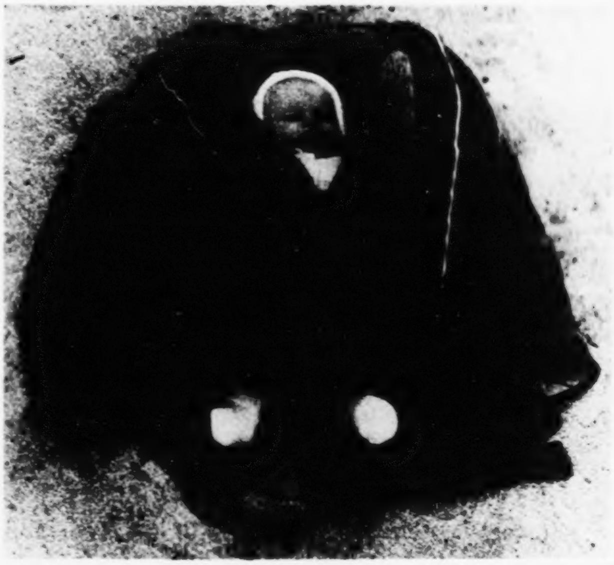
For example, 4 of the 9 hospitals which reported undercounting the numbers of drug-exposed newborns and/or substance-abusing pregnant women showed a marked increase in the number of drug-exposed newborns simultaneous to hospital efforts to maintain data.

c. Three of the four private hospitals surveyed (Miami, San Francisco, Seattle) did not have data on drug-exposed newborns or substance-abusing mothers. None of these three reported an incidence of drug-exposed newborns over 2%. The hospitals said that the substance-abusing women primarily attended the area public hospital, except in emergency cases. The obstetricians and neonatologists explained that they did not routinely inquire about drug use when taking maternal history.

2. Bandstra, E.S., Steele, B.W., Burkett, G.T., Palow, D.C., Levandoski, N., and Rodriguez, V. "Prevalence of Perinatal Cocaine Exposure in an Urban Multi-ethnic Population." Pediatr. Res, April, 1989 (In press).

Letters to the Editors

In attempting to provide a rationale for "residential care" (see *Infants in Institutions Revisited* in *Zero to Three*, February, 1989) Dr. Sally Provence suggests that it may possible to "to modify and individualize care in accordance with the state of this child at this time" in such settings. Ironically this is precisely the type of care which most agency/institution officials would claim that they provide in their "congregate care" facilities on a day to day basis. Certainly reasonable people could disagree as to whether this is possible or not and whether it is the present day reality or not.



JOHN DAVID ARMS

Unfortunately, during the last four years in New York City, the reality has resembled Dr. Provence's 1962 research, *Infants in Institutions*, rather than her 1989 theory of therapeutic residences for very young children. The Public Interest Health Consortium for New York City has attempted to outline the tragic reality of children in infant shelters by analyzing the quarterly inspection reports of the New York City Department of Health as regards the conditions in the shelters.

Since 1985, literally thousands of very young children, many babies, have spent weeks, months, and even years living in group settings such as acute care hospital wards as well as temporary shelters which are located in houses, apartment buildings and old school buildings. The shelters care for 6-20 children, although one such facility housed 60-70 children at one point while 10 workers tried to take care of them. We estimate that at least 2,000 children, most under 6 years of age, have passed through the shelters in the last few years while an additional cohort of hundreds if not thousands of babies have lived in hospital wards for weeks or months.

At present, on any given day approximately 135 children, with a mean age of 18-21 months, live in shelters which have been persistently plagued with the same problems: safety hazards; lack of therapeutic services for handicapped children; contagion, leading to diarrhea epidemics; poor medical care, including lack of or underimmunization; poorly paid and trained workers providing custodial care for already neglected and abused children, etc. There have even been *deaths*. On average the children stay for at least two months, although children with special needs may stay longer and children "without problems" may stay for shorter periods.

Limiting our analysis for the moment, we see at least two issues here: the regulations governing group care for very young children and the enforcement of those regulations.

In New York City regulations governing particularly the smaller facilities (maximum of 6 children) are very sketchy. Health supervision and provision for educational/recreational needs are defined by vacuous phrases such as "provided in accordance with his needs" and "shall meet ...... needs." There are virtually no qualifications required for the individuals caring for these vulnerable children either. When one looks at the age distribution regulations, particularly the numbers of children less than two years of age allowed, one can see that the historic intent of the regulations governing facilities of all sizes was to *exclude* very young children from living in such settings. Certainly there was not anticipation that large numbers of fragile handicapped children would be living in the shelter system.

To make matters worse, the guidelines promulgated by the child welfare authorities of the State of New York are not vigorously enforced by them. Neither will public health authorities enforce those guidelines or utilize elements of the public health code in New York City to penalize the public or private agencies running these facilities. Repeatedly the inspection reports document too many children as such or too many children under age two housed in the shelters. Recently, in violation of laws prohibiting children living in basements, two toddlers with AIDS and possibly tuberculosis were sequestered in the basement of a shelter for two weeks. Contagion is continually a problem. Dozens of children have been hospitalized because of diarrhea epidemics. The agencies with potential enforcement responsibilities appear to be paralyzed by political considerations, only intermittently interested at all, or completely uninvolved.

The result is that the children are subject to the *good will* of the collapsing New York City welfare and foster care system, which has witnessed an explosion of 10-15 thousand children, many babies, in the foster care system since 1985 and approximately 1000 deaths secondary to neglect and abuse in the last decade. Clearly good will is not a guarantee of individualized care in a system so completely overwhelmed.

Furthermore, the theory of therapeutic residences and the model described in Los Angeles (see *The Infant and Toddler Therapeutic Shelter: A Secure Base* by Sheila Anderson in the February, 1989 *Zero to Three*) declare "intensive assistance to parents" to be an integral part of the model. This is difficult to obtain in New York City by *any* parent with a child in the foster care system, not only for those with children in the shelter system. The New York State Child Welfare Reform Act, legislated a decade ago in order to try to keep families intact or reunite them, has been declared all but moribund by advocates and even some government officials such as the New York State Comptroller. The present Commissioner of the New York City agency responsible for human services even declared preventive services to be "mushy" in a recent *New York Times* article.

As a result, the provision of housing to avoid foster care placement of children rarely occurs. Pregnant addicted women find it almost impossible to find drug treatment programs which can meet their needs as pregnant women and later as mothers. In fact the stunning collapse of the health and welfare of young women of childbearing age in New York City has yet to be properly addressed. This health crisis stands at the core of the disintegration of family life in the poorest neighborhoods and the stunning traffic of children into the foster care system and finally the shelters. These women often suffer from the double jeopardy of marginal living conditions and substance abuse. The epidemic of early *deaths* of this same group of women during the 80's is at the heart of the rapidly evolving population of oprhans here.

We must respond to the rapid evolution of the temporary institutionalization of very young children and the threat of the permanent institutionalization of thousands upon thousands of orphans. The expertise of the NCCIP community is needed for a variety of things: analysis of the present tragic realities; development of models and regulations for "healing" and "educating" the broken children; advocacy for the widespread implementation of same on an emergency basis; and finally the development of models for intensive assistance of parents which combines NCCIP's historic family intervention/infant psychiatry concepts with innovative drug treatment modalities such as acupuncture.

All of this, though, will be insufficient unless our society as a whole joins with the communities in which these children struggle to survive and finds ways of empowering those communities to heal and educate their most vulnerable members in biological, kinship, foster, or adoptive *families within* the community.

Willowbrook lurks.

Sincerely,

James Rempel, R.N.
Brooklyn, New York

As is well known, clinical work with infants and young children, perhaps more than any other endeavor, highlights the need for many different disciplines to work together. Both on a practical and theoretical level, we are finding greater complementarity in the approaches developed by different disciplines toward understanding infant and child behavior.

There was discussion in my article in the September, 1988 issue of *Zero to Three* as well as more recently (Greenspan, 1989; Greenspan and Greenspan, 1989) of practical strategies for integrating approaches developed by occupational and physical therapists for improving motor skills with approaches to facilitating emotional development.

Deserving special emphasis in these discussions is the pioneering work of Jean Ayers (1964), who in the early 1960's identified the important role of differences in sensory reactivity and processing and aspects of motor patterns for later complex behavioral and learning

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abilities in infants and children. Interestingly, around this time, investigators in the field of mental health such as Sibylle Escalona (1968), and Barbara Fish (1965), were also reporting sensory differences in infants and children evidencing psychiatric risk and/or disturbances.

While there is debate about the impact of early sensory and motor differences on later behavior and about theories developed to explain the relationship between early sensory motor differences and later learning capacity, there can be little doubt about the gifted and important clinical observations of Jean Ayers and the many outstanding clinicians in the field of occupational therapy who have explored and currently continue to refine this area of inquiry.

A future challenge is for the many different disciplines concerned with how infants and young children regulate and organize affect and behavior to work together to better understand how early individual differences contribute to both adaptive and maladaptive developmental processes.

Stanley I. Greenspan, M.D.

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National Center Notes

by Eleanor S. Szanton

An understanding of how the infant or toddler is developing across many domains, within the context of the family, is essential to providing those supports to parents and child that will build on unique strengths and address individual needs. A new publication, *Identifying and Assessing Young Disabled and Developmentally Vulnerable Children and Their Families: Recommended Guidelines,* addresses new opportunities made possible by the expansion of Medicaid and the enactment of P.L. 99-457, the Education of the Handicapped Act Amendments of 1986. The publication is authored by Dr. Samuel Meisels and a task force of individuals with diverse expertise in one or another aspect of screening and assessment, including the consumer perspective. The publication was conceived and supported by the National Early Chilodhood Technical Assistance System (NEC*TAS), coordinated out of the Frank Porter Graham Child Development Center at the University of North Carolina. NCCIP, as a subcontractor to the NEC*TAS system, took the lead in developing the publication. Three members of NCCIP's Board served on the Task Force besides Dr. Meisels—Dr. Asa Hilliard, Dr. Sally Provence, and Dr. G. Gordon Williamson. Several members of NCCIP staff also played key roles.

The publication will be made available free to all fifty states and ten territories taking part in PL 99-457, all of whom are required to design and put in place a policy for establishing who from birth to six years will be eligible for services and how they will be identified as needing them. (Additionally, states may decide if they wish to serve those with already discernible and established problems, or whether they wish to include children who are at risk as well.) The publication is designed to be useful also to individual service providers, as well as to those who organize and fund services.

As the authors of the *Guidelines* note, public policy has in some ways run ahead of our ability to implement it, since the state of the art in screening and assessing (especially) very young children with any predictive validity is not well developed.

On the other hand, the state of the art is far more developed than it was only a few years ago. This is because: (1) research on the dynamics of infant development has become much more finely delineated; (2) the field now has the benefit of articulate parents as resourceful and thoughtful commentators on the assessment process; and (3) a number of significant epidemiological studies have shown what combinations of risk factors are most likely to result in developmental problems, and therefore where screening and assessment would pick up most children in need of further help.

The publication is presently in press and will be available from NCCIP in early July.

We would like take this opportunity to wish our best to Surgeon General Everett Koop, as he retires from office. Dr. Koop's constant support of family-centered, community-based coordinated care for children with special health care needs was tireless. Beyond this his immense prestige and energy contributed enormously to our nation's efforts to protect babies from exposure to HIV, nicotine, and other noxious elements in utero. His efforts to ensure that infants born with handicapping conditions or other forms of medical fragility could lead lives as personally rewarding as those of many other children were remarkable. He has changed our thinking in a number of ways. On behalf of our many constituents, we praise his courage and effectiveness.

Publications

Relationship Disturbances in Early Childhood: A Developmental Approach (1989)—Arnold J. Sameroff and Robert N. Emde, editors (Basic Books, Inc., 10 East 53rd Street, New York, NY 10022) $24.95.

Only through the study of early relationships, argue the contributors to this volume, can we fully comprehend early individual development. The contributors—Arnold Sameroff, Robert Emde, Daniel Stern, Alan Sroufe, Thomas Anders, Arthur Parmelee, Herbert Leiderman, and David Reiss—began work in 1984-85 as a special-project group at the Center for Advanced Study in the Behavioral Sciences in Stanford, California. As clinicians and developmental psychologists, the group was interested in integrating knowledge from a variety of research contexts in order to formulate a developmental model that would lead to a classification scheme for early relationship disorders.

The group found it useful to use the concepts of **perturbation, disturbance,** and **disorder** in evaluating relationships in their developmental context. The young child's struggles to achieve developmental milestones produce expected perturbations that require family adaptation. To the extent that the family is unable to adapt, relationships become disturbed and behavioral difficulties become apparent in some areas. Disorder results when behavioral problems spill over into other domains and constrict the normative activities of either child or parent. The volume is divided into three parts: chapters on development present the dynamic principles through which early relationships must be understood, according to the authors; chapters on disturbance explore the distortions to be found in the development of relationships; chapters on context examine the variation found in the organization of relationships produced by developmental status, family, and cultural context. The authors point out the need for further research and theory building concerning relationships throughout the lifespan and the effect of relationships on other relationships.

The Essential Partnership: How Parents and Children Can Meet the Emotional Challenges of Infancy and Childhood (1989)—Stanley Greenspan and Nancy Thorndike Greenspan (Viking Penguin Inc., 40 West 23rd Street, New York, NY 10010) $18.95.

As a sequel to their earlier book, *First Feelings*, Stanley Greenspan and Nancy Thorndike Greenspan explore the "essential partnership" of the ongoing parent-child relationship as a context for healthy emotional growth and the solution of common developmental problems. The authors address mood and self-esteem; sexuality, pleasure and excitement; anger and aggression; separation anxiety, fears, sadness and competition; the capacity to concentrate, process information and learn; and peer and group relationships. They suggest that parents tune in to their children's interests and concerns by engaging in spontaneous, unstructured play during which the parent tries to follow the child's lead. During this "floor time," the child can experience being loved, understood and accepted for all his feelings; problem solving with the parent will develop his sense of logical connection to the world of reality, and limit setting will result in an ability to feel secure in his own internal limits.

Ordinary Families, Special Children (1989)—Milton Seligman and Rosalyn Benjamin Darling (The Guilford Press, 72 Spring Street, New York, NY 10012) $30.00.

This volume represents an effort to examine the intertwined family, child and social system variables that contribute to the response of families to childhood disability; to identify those elements of family and community life that facilitate or detract from the family members' ability to cope; and to describe relevant intervention strategies for families. The authors base their discussion on both empirical investigations and personal accounts from family members. Individual chapters review social systems and family systems concepts; parents' reactions to first information about a child's disability; effects on the family as a system; effects on siblings, fathers and grandparents; models of intervention; cultural and subcultural reactions to childhood disability; professional-family interaction and partnership; and issues related to Individualized Family Service Plans under P.L. 99-457.

The Common Good: Social Welfare and the American Future (1989)—Policy Recommendations of the Executive Panel, Ford Foundation Project on Social Welfare and the American Future. (The Ford Foundation Office of Communications, 320 East 43 Street, New York, NY 10017) Free of charge.

This report, representing a three-year research and discussion effort by an 11-member panel of business, civic, labor and civil rights leaders and educators, recommends a variety of new and expanded services designed to improve a social welfare system seen as leaving millions of Americans dependent, vulnerable and without security at critical points in their lives. Recommendations include providing treatment on demand for all seeking help with drug or alcohol problems; tripling the number of 3- and 4-year-olds served by Head Start; making the Federal day care tax credit refundable; full funding for the WIC program; creating minimum national standards for ADFC payments; increasing the Federal minimum wage; establishing access for all pregnant women to prenatal and well-baby clinics; and expanding Medicaid to cover care for poor children and adults. Panel members included Irving S. Shapiro, Charles Hamilton, Mitchell Sviridoff, Sol Chaikin, James Ellis, Robert Erburu, John Filer, Hanna Gray, Albert Hirschman, Vernon Jordan, Eleanor Holmes Norton and Henry Schacht.

Young Unwed Fathers: Research Review, Policy Dilemmas and Options - Summary Report (1988)—Jacqueline Smollar and Theodora Ooms (Shared Resource Center, P.O. Box 2309, Rockville, MD 20852)

$5.00; ten commissioned papers also available for $5.00 each.

This publication is the product of a project begun in October, 1986 to examine characteristics and profiles of unwed fathers up to 25 years of age as well as some of the Federal and State programs and initiatives geared to this group. The project was a collaboration between researchers at the Family Impact Seminar at Catholic University, MAXIMUS, Inc., McLean, Virginia, and the Office of The Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. The 91-page summary report presents major findings concerning the current state of knowledge about young unwed fathers; their legal and moral rights and responsibilities; the experience of job training, adolescent pregnancy and parenting, AFDC and other programs; and possible program and policy options. Summaries of ten commissioned papers, federal program descriptions, a review of research in progress pertaining to young fathers, and a list of selected references are also provided.

Directory of Hospital Psychosocial Policies and Programs (1988)—Michael C. Roberts, Mariella J. Maieron and James Collier (Association for the Care of Children's Health, 5615 Wisconsin Avenue, N.W., Washington, D.C. 20016) $26.00.

This directory presents findings from a 1988 hospital survey of policies, programs and services in 286 U.S. and Canadian hospitals serving children. The survey items focus on policies which potentially decrease the amount of separation from family members; programs geared toward familiarizing the patient and family with the hospital and medical procedures; support services for children and families; hospital policies and programs that directly recognize the developmental needs of children; and practices that facilitate parent/professional collaboration. The survey replicated to a large extent one carried out in 1981; findings revealed that while additional child-and family centered policies and programs have been instituted by many hospitals since 1981, financial restraints in health care have forced cutbacks or limited growth of these polices and programs. The directory lists individual hospitals that have innovative programs including laundry, shower and food preparation facilities for parents; parents in induction and recovery rooms; care by parent programs; pre-admission programs designed specifically for infants and toddlers; family resources libraries; parent advisory boards; respite care; hospice care; sick child day care; and day care for children with special health care needs.

Unstable Ideas: Temperament, Cognition and Self (1989)—Jerome Kagan (Harvard University Press, Cambridge, MA 02138) $25.00.

The nine essays in this volume place within an historical context three concepts central to contemporary psychological investigation and theory building: temperament, cognition, and self. Kagan traces the rise of behaviorism, the attraction of the term "freedom" to describe the state of the child, attachment theory, and the emergence of interest in cognitive development. In discussing current enthusiasm for research on perception and attachment processes in the infant, Kagan notes that the infant became an attractive research subject because of the appearance of new methods like the object permanence procedure and the Strange Situation paradigm; he also remarks that the mood of anxiety that characterizes our historical era may be projected onto the infant and young child, contributing to scientific curiosity about the child's anxiety, trust, and attachment.

A corrective is needed, argues Kagan, to the assumption that knowledge from "relevant" research can guide ethical decisions about the education and socialization of children. The results of empirical research cannot be the sole guide for judging what is psychologically good for children or families—value decisions, he notes, must be made by individuals and policymakers.

Family Day Care Rating Scale (1989)—Thelma Harms and Richard M. Clifford (Teachers College Press, 1234 Amsterdam Avenue, New York, New York 10027) $8.95 (scale); $6.95 (30 score sheets).

The Family Day Care Rating Scale (FDCRS) is an adaptation of Harms and Clifford's Early Childhood Environment Rating Scale; adaptation and field testing have been underway since 1980. In an effort to define quality of family day care comprehensively, the FDCRS covers six categories with its 32 items: Space and Furnishings for Care and Learning, Basic Care, Language and Reasoning, Learning Activities, Social Development, and Adult Needs. Each item is described in four levels of quality: inadequate (does not even meet custodial care needs), minimal (meets custodial needs and, to some degree, basic developmental needs), good (meets developmental needs), or excellent (high-quality personalized care). Eight additional items are included for rating a day care home's provisions for special-needs children. Descriptions cover the needs of a range of ages from infancy through kindergarten. Reliability and validity of the FDCRS are documented by a variety of findings; the scale is designed for use as a self-assessment tool for family day care providers, as a quality measure for state and private monitoring agencies, and as a guide for parents.

Stress and Coping Across Development (1988)—Tiffany M. Field, Philip N. McCabe and Neil Schneiderman, editors (Lawrence Erlbaum Associates, 365 Broadway, Hillsdale, NJ 07642) $34.95.

This is the second volume based on the annual University of Miami Symposia on Stress and Coping, which are focused on current research related to developmental, physical and mental health aspects of these phenomena. The volume is divided into sections dealing with infancy, childhood and adulthood. In the first of three chapters on infancy, Saul Schanberg and Tiffany Field explore maternal deprivation and supplemental stimulation in animals, premature human neonates, and infants failing to thrive. C. Sue Carter discusses the hypothesis that patterns of infant feeding and related early experiences provide a foundation for stress management. A. Gianino and E.Z. Tronick propose a "mutual regulation model" for describing the infant's abilities to cope with stressful interaction with people or objects and the developmental changes in stability of these coping abilities.

Child Development Today and Tomorrow (1989)—William Damon, editor (Jossey-Bass, Inc., 350 Sansome Street, San Francisco, CA 94104) $35.00.

The twenty contributions in this volume are designed, according to its editor, to present new ideas that have arisen out of contemporary research and theory on children's development and to point the way to the field's future directions. Sections address the social and cultural contexts of development, emotional development, intellectual achievement and social development, from infancy through adolescence. In a chapter entitled "Infants in Relation: Performers, Pupils, and Partners," Ina C. Uzgiris reviews the process by which researchers have come to see infant-adult interaction as a mutually regulated interpersonal exchange. She notes taht in future research it will be important to distinguish the study on interpersonal interaction as a basic form of human activity from the study of contextual effects on various activities in a social setting; she argues for a developmental perspective in research and a focus on "how incipient competencies are practiced, particularized and perfected."

Implementing Early Intervention (1989)—Carol Fingley, editor (Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, MD 21285-0624) $29.00.

Its editor describes this volume as "a guide for planners and service providers as they negotiate their way through the variety of practical considerations that are important to the quality of services that are being provided in early intervention programs" for young children with handicaps and their families. Many of the chapters are written or co-authored by staff of the Early Intervention Research Institute. Developmental Center for Handicapped Persons, Utah State University. Chapters address best practices, including determining eligibility; administrative concerns, including program costs, staff development, interagency collaboration and evaluation; implementing interventions directed toward specific developmental areas; and "related concerns," including health and an overview of parent/professional relationships in early intervention.

SEPTEMBER *ZERO TO THREE* TO FOCUS ON TRAINING

The September, 1989, issue of *Zero to Three* will focus on the training of practitioners who work with infants, toddlers and their families. Space will be available in a special section of that issue to list training opportunities, including pre-service programs, on-site and community-wide in-service opportunities, and continuing education offerings.

Readers who wish to publicize new or ongoing training programs in this issue should submit an announcement that includes the following information: sponsoring institution; type of training program; eligibility requirements for trainees; special features of the program; availability of stipends; name, address, and phone number for further information. **Submissions must be received by August 1, 1989.** They should be sent to Linda Eggbeer, NCCIP, 733 15th Street, N.W., Suite 912, Washington, D.C. 20005.

Inclusion in the listing will not imply any review or endorsement by the National Center for Clinical Infant Programs.

Conference Call

July, 1989

July 19-21: The *Family Resource Coalition* will hold a 1989 Summer Training Institute at DePaul University in Chicago, Illinois for professionals who want to learn about developments in prevention services for families and how to initiate parent education classes and parent support groups. For information contact FRC, 230 North Michigan Avenue, Suite 1625, Chicago, IL 60601, tel: (312) 726-4750.

July 24-28; August 7-11: *Child Development Resources* will hold its fourth annual Early Intervention Summer Institute in Williamsburg, Virginia in July and in Denver, Colorado in August. Entitled "Critical Issues in Implementation" of P.L. 99-457, the institute will have one content strand on direct service issues with presentations by Diane Bricker, Julian J. Woods Cripe, Pam Winton, and Ulrike Seufert-Jeffer and a second content strand on administrative issues, with presentations by Howard Garner, Susan Fowler, and Janeen and W. Scott Taylor. For more information, contact Georgia Mamangakis at Early Intervention Summer Institute, Institute, P.O. Box 299, Lightfoot, VA 23090, tel: (804) 565-0303.

August, 1989

August 3-6: The *National Association for Family Day Care* will hold its fourth national conference in San Mateo, California (near San Francisco). June Sale and Lendon Smith will be featured speakers. For information, write to NAFDC Conference, 815 15th Street, N.W., Suite 928, Washington, D.C. 20005.

August 6-8: *The University of Tennessee* will sponsor the "Second International Conference on Mediated Learning Experience," to be held in Knoxville, Tennessee. Reuven Feuerstein will moderate the conference, which will explore the application of MLE as an assessment, therapeutic and educational intervention. Contact the Department of Conferences, 600 Henley Street, P.O. Box 2648, Knoxville, TN 37901, tel: (615) 974-0250.

August 21-25: The *Child Development Division* of the *California State Department of Education* and the *Center for Child and Family Studies, Far West Laboratory for Educational Research and Development* will sponsor the First Annual Infant/Toddler Institute in Anaheim, California, with the theme, "From Vision to Reality." Speakers will include J. Ronald Lally, Carol Brunson Phillips, Mary Lane, Magda Gerber, Louise Derman-Sparks, Janet Gonzalez-Mena, June Sale, Yolanda Torres, and Vivian Weinstein, among others. Contact Infant/Toddler Committee, Child Development Division, California State Department of Education, 560 J Street, Suite 220, Sacramento, CA 95814, tel: (916) 322-6233.

August 22-25: The *Infant-Parent Institute* will offer its ninth annual Brief Summer Course in Infant Mental Health in Champaign, Illinois. Michael Trout will be principal instructor, making extensive use of case materials. Contact Mr. Trout at the Infant-Parent Institute, 328 North Neil, Champaign, IL 61820, tel: (217) 352-4060.

September, 1989

September 17-20: The *University Affiliated Cincinnati Center for Developmental Disorders* will hold the first of five annual workshops in Cincinnati on "Nutritional Needs of the Child with a Chronic Illness or Handicap." Contact Shirley Ekvall, Children's Hospital Medical Center, 3300 Elland Avenue, Cincinnati, OH 45229.

September 20-24: The *World Association for Infant Psychiatry and Allied Disciplines (WAIPAD)* will hold the Fourth World Congress on Infant Psychiatry and Allied Disciplines in Lugano, Switzerland on the theme "New Directions in Infancy." For information write to Hiram E. Fitzgerald, Department of Psychology, Psychology Research Building, Michigan State University, East Lansing, MI 48824-1117.

September 21-24: *Parent Care* will sponsor its sixth annual conference in Lincolnshire, Illinois, north of Chicago. Addressing the theme, "New Directions for a New Decade," faculty will include Tim Miller, Leigh Ware, Mark Evans, Herbert Sandmire, Penny Rutledge, Sister Jane Marie Lamb, Gene Anderson, Bob White, Bob Cicco, Michael Hynan, Sol Gordon, John Hartline, Lynn Blanchard, Penny Anderson, Tim Healy, and Rita Kinstler. Contact Lutheran General Children's Medical Center, Concerned Parents Organization, 1775 Dempster Street, Park Ridge, IL 60068 1174, tel: (312) 696-8214.

October, 1989

October 5-7: *The American Medical Association* will convene a national conference in Chicago, Illinois on the prevention of family violence and victimization. Contact Marshall Rosman, Department of Mental Health, AMA 535 N. Dearborn St., Chicago, IL 60610, tel: (312) 645-5000.

October 11-15: *The American Academy of Child and Adolescent Psychiatry* will hold its 36th annual meeting in New York City. Contact AACAP, 3515 Wisconsin Avenue, N.W., Washington, D.C. 20016, tel: (202) 966-7300.

October 13-15: *The National Down Syndrome Congress* will hold its 17th annual convention in Denver, Colorado. Plenary session presenters will include Marie Bristol, David Patterson, Josef Reum, Derrick Dufresne, Reed Martin, and Thomas Powell. Contact the National Down Syndrome Congress, 1800 Dempster Street, Park Ridge, IL 60068-1146, tel: 1-800-232-NDSC.

October 13-15: The *Healthy Mothers, Healthy Babies Coalition* will hold its national conference in Arlington, Virginia on the theme, "The Year 2000: Can We Get There from Here?" The conference will include plenary sessions, workshops and roundtables, with a preconference workshop on developing materials for low-literacy audiences. Write or call Healthy Mothers, Healthy Babies, 409 12th St., S.W., Washington, D.C. 20024-2188, tel: (202) 863-2458.

October 21: The *Infant-Toddler Consortium* will hold its second annual conference in Berkeley, California. The theme will be "Early Challenges: Caring for Children from Birth to Three". Ellen Galinsky will be keynote speaker, and Jeree Pawl, J. Ronald Lally, and Magda Gerber will be among the pre-session presenters. Call Nadja Christian at (415) 464-4199 for more information.

October 26-29: *The American Association for Marriage and Family Therapy* will hold its 47th annual conference, entitled "Building Bridges: Creating Balance," in San Francisco. Presenters will include Evan Imber-Black, Salvador Minuchin, Monica McGoldrick, Carl Whitaker, and Ivan Nagy, among others. Contact AAMFT Conference, 1717 K Street, N.W. #407, Washington, D.C. 20006, tel: (202) 429-1825.

November, 1989

November 9-14: The *Society for Behavioral Pediatrics* will hold its 7th annual scientific meeting, a festschrift symposium in honor of T. Berry Brazelton, and a series of workshops in Cambridge, Massachusetts. Presenters will include Barry Zuckerman, Barry Lester, Peter Dawson, Bernice Weissbourd, Gloria Rubin, Francine Jacobs, Ann Rosewater, John Kennell, Melvin Levine, T. Berry Brazelton, Jack Shonkoff, Linda Gilkerson, Edward Tronick, Heidelise Als,l Kathryn Barnard, Jerome Bruner, Robert Emde,and Tiffany Field. Call Noreen Spota at (215) 248-9168.

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This index groups by topic the articles and reviews of publications that have appeared in *Zero to Three* from September, 1988 through June, 1989. When an item is listed as *"review of"* this means that a brief summary of the publication appears in the issue of *Zero to Three* indicated.

Copies of the index for Volumes I through VIII are available on request from the National Center for Clinical Infant Programs. Back issues of *Zero to Three* are available for $4 each from NCCIP, 733 15th Street, N.W., Suite 912, Washington, D.C. 20005. Payment must accompany orders. NCCIP reserves the right to supply photocopies of issues no longer in print.

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